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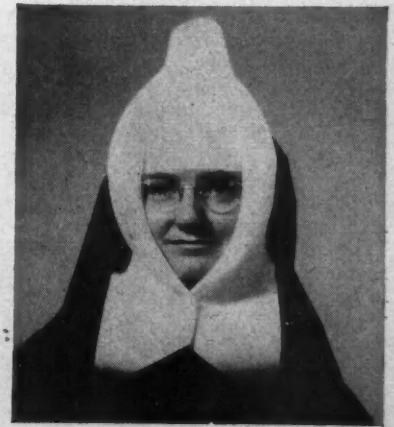
Peace on Earth to Men of Good Will

THESE FIRST CHRISTMAS greetings brought by angels to the shepherds on Judea's hillside re-echo today as we prepare for the great feast of Christmas. To many, peace in its widest sense means an absence of war but, on closer consideration, peace is possessed by individuals regardless of externals, and the longing for it is within us all. It is an inner quality which gives poise and tranquillity and a freedom from disturbance or agitation even when beset by trials.

Men of good will are those who fulfil their duty to the best of their ability and do not count the cost. As nurses, we have ample opportunity to qualify as "men of good will," whether our task lies in the direct or the indirect care of the patient. Ours is essentially a service to mankind and embraces care of the sick, prevention of disease, and conservation of health. In all of these, consideration of the whole person is essential — his spiritual, mental, emotional and physical well-being, and his physical and social environment. Nursing service in any capacity includes health service, health education, and health preservation, given to the individual, the family, and the community.

In addition to physical, intellectual and moral fitness, nursing demands a right intention and attitude. This does not exclude the ambition of reasonable working conditions; it is only right and just that good personnel policies prevail for nurses. But it is the intangibles which constitute the inner spirit of nursing and supply those deep satisfactions which come from having spent oneself in the service of human beings who needed this aid. The inspiration



Van Dyck, Montreal

SISTER MARY FELICITAS

and effort to give one's best establishes a bond between the nurse and the patient, a bond which is not just economic nor even medical but is a personal and a spiritual one. Sympathy and kindness are of paramount importance, based on the brotherhood of man united in a common creation and the common fatherhood of God. It is the nurse's special privilege to bring comfort and solace to all these needy ones.

It is when the tangible rewards assume too large a portion that the spirit of nursing suffers a setback. From thence arise those attitudes which could cause people to consider nurses as hardened, unsympathetic and indifferent to their needs.

Wholehearted service qualifies the nurse as a person of good will and to her the angels' message takes on a new meaning and a greater significance. In a special manner peace and content are hers, for having given generously of herself she makes room in her heart for joy and happiness. These cannot exist with selfishness.

Christmas is a family feast and nurses are also members of families. But many nurses will be on duty on Christmas Day, for illness knows no vacation. Rest assured that your devotion to the ailing members of God's family will not go unrewarded, if you go about your tasks with alacrity and devotion. The spirit of Christmas is essentially the spirit of giving, even at the cost of sacrifice. It is such giving which implies greater love and which brings the greatest happiness to the giver.

May the Prince of Peace bring you the joy of Christmas and the blessing of true peace!

SISTER MARY FELICITAS, s.p., M.S.N.
St. Mary's Hospital, Montreal

Christmas Facts, Foods and Fancies

RUTH LUNDGREN

FOR ALMOST TWO THOUSAND YEARS Christmas has been the most celebrated holiday of every year. Celebrated by all kinds of people in all parts of the world — people whose taste in living and eating differ but whose feeling about Christmas is the same.

Our Christmases never get "better" as the years go by, because the Christmases of our childhood are "best." Perhaps it is for this reason that we draw on the traditions and symbols of Christmas with which our parents brightened our early Christmases.

To everybody, Christmas means shining lights and shining eyes, gaiety, laughter, peace and joy, as well as prayerful thanksgiving. Christmas means good cheer — and good food. Christmas is stuffed goose, plum pudding, roast beef, a wassail bowl, magi cakes or lebkuchen — depending on where you come from and what your inherited traditions are. Christmas is a spicy smell, filling homes from one end of Christendom to the other.

It was always so, with Christmas. This, of all times to people everywhere, is the time of seasoning — the time when the magic of cinnamon, powdered cloves, ginger, nutmeg, anise, allspice and aromatic bitters are brought to bear on the foods that will grace the festive board. And the Christmas feast is an integral part of the holiday.

In the time of the Saxons, the festive board was spread with its "bordcloth" and the guests waited for the two specialties that marked Christmas: the peacock and the boar's head. The peacock, always borne to the table by a lady, perhaps the most beautiful of the female guests, sometimes arrived in the form of a pie, with the head of the bird protruding from one side of the crust and its widespread tail from the other. More often, the bird was

1870 drawing from the Bettmann Archive

A Christmas of Yesteryear

skinned, stuffed with herbs, and roasted. Just before it was served, the skin was put back on.

Legend has it that the boar's head was served to commemorate the brave English student who was attacked by a wild boar while he studied Aristotle in the woods. As the beast bore down upon him, the intrepid young man crammed the philosopher down the throat of the savage animal. Hence, the head of the boar was always served with a large apple stuffed in its mouth.

The English Christmas feast of that era ended always with a dish unknown to modern times. It was called "frumenty" and consisted of wheat boiled till the grains burst. When the mixture was cool it was strained and boiled again with broth or milk and yolks of eggs. As the years passed, more imaginative cooks added other things: raisins, prunes, mace. By 1670, some enterprising culinary artist had revised the recipe further and chopped in some suet, to produce the first plum pudding. Today, plum pudding is as traditional in Canadian Christmas feasting as it is in English with further embellishment of the Old World recipes by the addition of new flavoring agents and seasonings.

Mince pie is also a decidedly British addition to the Christmas feast. As early as 1596, "shrid pye," or shredded pie, was popular. The delicacy symbolizes the gifts of the Wise Men to the Christchild, representing a compound of the choicest spices of the world. Many of us still make our own mincemeat, a rewarding experience in itself. The traditional way to make a mincemeat pie crust is with a cross-latticed top. This represents the hayrack of a stable, commemorating the birth of the Christchild in a lowly manger.

To the English, too, we owe the origin of the mistletoe kiss. The Druid priests of old England at Christmas time went out into the woods and cut mistletoe from the boughs. They bless-

With cross-latticed top

ed the branches and gave them to young men to carry to the homes of the people. It was the duty of the populace to accept the mistletoe and to show their appreciation for the blessing by offering alms to the young men. The mistletoe was then hung over the doorposts of the homes and it was thought that only happiness could pass under the branch.

In Scandinavia the festive "bordcloth" becomes "smorgasbord," which literally translated means "sandwich-table." This, however, is a meagre description of the untold varieties of delicacies which adorn the Christmas table of the Swedish, Norwegian, and Danish people — and their descendants in this country. Here are found, in wondrous array, cold roast pork with currant jelly, veal with mustard sauce, jellied calf tongues and radish roses, smoked whitefish with caper, pickled herring in dill sauce, anchovies, smoked salmon, pickled pigs' feet, assorted fruit and vegetable molds to create color contrast, molded fish mousses, endless varieties of cheeses, brown beans cooked in molasses, meat balls, and half a dozen kinds of spiced Christmas breads. Many of the latter are baked only at the holiday season and are as much a part of Christmas as the Christmas-dawn service, Jullotta, held in all the churches.

Christmas, in all countries, has always called for special decorations. The earliest were the handiest — greens from the forests. Since the season determined that these be evergreens, the "Christmas tree" that evolved was a pine or fir. The use of trinkets on the tree dates from the early Roman days when masks of Bacchus were hung on trees to impart fertility to those who gazed upon them.

To accept a bunch of edelweiss on Christmas, in Switzerland, is also to accept the man who proffered it. In Denmark, some of the bread baked at Christmas is mixed with the seed at sowing time to ensure an abundant harvest. In Spain, cows are honored at Christmas time because it is believed that cattle breathed upon the Christ-child to keep him warm.

In Ireland, if a person dies at Christmas Eve, the belief is that his soul automatically enters the gates of Paradise. Ireland, too, has a traditional Christmas drink, known only in that country. Called "Lambswool," it is made by bruising roasted apples and mixing the juice with ale or milk. It is served with apples and nuts and considered indispensable on Christmas Eve.

Weinachten, Holy Night, is Christmas to all in Germany. These people have maintained their traditions through centuries and many of their customs have been adopted throughout the world. It was the German princess of Mecklenburg who introduced the first Christmas tree to France in 1840. Before then, this decoration was not a part of the French celebration. Today, at Christmas, the streets and shop windows of large cities throughout France are bright with decorated trees. Everybody who has German ancestry — or German friends — knows the typical Christmas cookies: the lebkuchen. It takes two days to make this wondrous children's delight but the general consensus among people who have sampled lebkuchen is that they are worth the time and effort.

Happy Christmas, Everybody!

Coronation Medal

Members of the Canadian Nurses' Association will rejoice over the news received just as the *Journal* goes to press that to our national president, Miss Helen G. McArthur, has come the honor of receiving a Medal commemorating the Coronation of Her Majesty, Queen Elizabeth II. We shall look forward with pride to seeing Miss McArthur wear this decoration at the forthcoming Biennial Convention.

Treatment of Acute Radiation Syndrome

LIEUT.-COL. F. C. PACE, C.D.

FOR THE PURPOSE of this article acute radiation sickness is a syndrome produced by the impingement on the whole body of the highly penetrating electro-magnetic emanations from an atomic bomb in the first minute after the detonation of the weapon. The impingement of these gamma radiations causes:

1. A physical disturbance in the atoms of the body constituents.
2. A series of disturbances in the biochemical and other mechanisms of the body.
3. The clinico-pathological condition termed variously acute radiation illness, acute radiation sickness, or radiation-syndrome.

This syndrome clinically is a triphasic illness. In the first phase, immediately after exposure and for a day or two after, occur nausea, vomiting, malaise and diarrhea. The second phase is a latent period wherein the patient feels well and may resume full activity for three to ten days. The third phase begins with a step-like fever, to be followed by anorexia, vomiting, diarrhea with blood stained stool, ulceration of the mouth and pharynx subcutaneous and generalized petechial hemorrhages, loss of scalp hair, anemia, secondary infections (often of the respiratory tract), with death in many cases between the third and sixth weeks. The chief histological changes are necrosis of lymphoid tissue and epithelial structure; damage to the blood-forming organs and reproductive cells; and initial lymphocytopenia followed by a fall in granulocytes and, from the third week on, aplastic anemia.

There are four possible means of preventing or treating this syndrome. These include:

1. The provision of adequate protection against these radiations.
2. The use of specific preventive treatment administered *before* exposure.
3. Specific treatment given *after* exposure.
4. Symptomatic and supportive treatment of symptoms and signs after they have developed.

In the present state of our knowledge the use of protective measures before exposure and of supportive and symptomatic treatment after infliction of the injury are the only procedures of any practical value, and specific treatment directed towards correcting the fundamental injury is still under experimental study. But because research may produce at some time a specific agent of great clinical value in the treatment of these cases it may prove interesting and profitable to review a few of the objects of current animal investigations in this field.

It is thought that a very basic effect of ionizing radiation on living tissue is the production of active oxidizing agents such as hydrogen peroxide from the water of the cells and body fluids. These oxidizing complexes are said to react with the sulfhydryl (SH) groups which are of such great importance to the activity of many enzymes; and so it has been postulated that, were we to "buffer" these SH radicals by the administration of compounds containing the same radical, the effects of irradiation could be reduced. Some investigators, using compounds such as glutathione and cysteine, have improved the survival times and rates when these substances have been given before exposure.

The foregoing is an example of an attempt at specific pre-treatment. One of specific post-treatment is as follows: several workers have shown that radiation produces certain histamine-like effects and have found high histamine levels in the blood of animals investi-

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Lieut.-Col. Pace is serving with the Royal Canadian Army Medical Corps. This article is the seventh of a series to be reprinted, with permission, from the special issue for Civil Defence, published by the *Canadian Medical Association Journal*.

gated. By treatment with anti-histaminics some improvement in the mortality rates of the animals has been gained. Another example of specific post-irradiation treatment is the exhibition of antiheparin agents on the theory that the hemorrhagic manifestations of the syndrome are due to the production of excessive amounts of heparin.

An interesting and promising line of work has risen from the observation that necrosis, thinning, and ulceration of the intestinal epithelium follow quickly upon the infliction of total body radiation. Such an injury permits toxic products and living organisms to gain access from the bowel through the damaged gut-lining to the general circulation, and thus to make a serious contribution to the symptomatology, pathology, and mortality of the syndrome. The administration of antibiotics that will control such infections has been shown to improve the animals' reactions and mortality rates.

That inhibition of the functions of the endocrine products of the adrenal cortex contributes to the clinical picture of acute radiation illness seems well established and good effects have been reported from the administration of desoxycorticosterone acetate and somatotropic hormone. Further promise is found in reports of benefit following injection of splenic extracts and of bone marrow substance.

The preceding notations are offered, not only for interest's sake but also to show that we should be prepared for the acceptance of specific therapies even though at the moment we cannot avail ourselves of them at clinical level. Within the axes of reference of practical therapeutics we have six aims:

1. Rest and nursing care.
2. Maintenance of fluid and electrolyte balances.
3. Adequate nutrition.
4. Control of infection.
5. Control of hemorrhage.
6. Treatment of anemia. Before considering these aims, however, we should examine the preventive possibilities offered by the effects of shielding and distance.

Shielding against radiation is familiar to every physician who has watched a radiographer work from behind a lead screen. Every material, including air itself, has a specific shielding-value against the electromagnetic radiations from an atomic bomb. This specific value is expressed as "half-thickness"—that is, that thickness of a material which will reduce the quantity of radiation impinging on it and passing through by 50%. The half-thickness value for a dense material like lead against gamma radiation is about half an inch; for concrete, about 3½ inches; for sand and earth about 7 inches.

Those persons who are sheltered in basements, heavily constructed buildings or even in ground-hollows would gain at least some protection against ionizing radiation, perhaps enough to make the difference between serious injury or death and otherwise. Besides this general shielding of the body, there are possibilities for local shielding of highly radio-sensitive regions, notably the upper abdomen: it has been found in animals that protection of the spleen during irradiation is followed by a lowered mortality. But of the practicability of localized body-shielding the writer is not prepared to judge.

The severity of the clinical reaction varies approximately with the dosage inflicted. It is highly probable that most persons who receive 500 roentgens or more of gamma radiation at a single dose (*i.e.*, within a minute or less) will die; that those who receive 400 R in the same manner will have a 50% chance of survival and if surviving will be seriously ill; that those who receive between 200 and 300 R will be ill and some will die; those with less than 200 R but more than 100 R will be mildly ill, and that those persons who get 100 R or less will show no symptomatic evidence of the injury inflicted. A discussion of the possible means of calculating dosages is not within the scope of this paper but two points should be noted—first, that the most satisfactory present means of determining dosage is by the use of the instruments of one sort or another carried on the person; and, second, that survivors who were unshielded at

the time of the blast and within 2,000 yards of ground-zero will require evacuation, even if they present no thermal or traumatic injury; while those at distances beyond 2,000—2,400 yards will probably need no treatment.

By whatever means dosage may be estimated, survivors of 400 R dosage or greater will be very ill and will need early, full-scale treatment. Treatment for cases that have had lesser dosages should be governed by the clinical condition but it must be realized that persons who are asymptomatic after smaller dosage should not be reexposed for weeks or months and then only if clinical and laboratory assessments indicate normal health.

Treatment

At this point we may examine the aims of supportive post-treatment and their application to cases of various degrees of severity.

Rest should be provided from the outset for all cases displaying early gastrointestinal symptoms, malaise or weakness. Such cases should be evacuated as lying or sitting cases, should be bed patients for at least two weeks, and should be returned to full activity only after careful assessment. Cases presenting more severe symptoms must have more extended rest.

Maintenance of fluid and electrolyte balance is particularly important in the presence of vomiting or diarrhea: indeed, emesis alone may be the chief factor in causing fluid and salt loss. It is, therefore, justifiable to take early measures to control this symptom. It has been suggested that wide use of such drugs as Gravol by exposed populations immediately after the explosion is a desirable "mass treatment" procedure. Any case that has lost much fluid by vomiting or diarrhea should have electrolytes supplied orally as normal saline, saline-sodium bicarbonate or saline-glucose; or if this mode of administration cannot be tolerated, such solutions should be administered parenterally, as soon as possible. Under acute catastrophic circumstances it is unlikely that elaborate laboratory tests could be carried out and it is suggested, therefore, that solutions of the types indicated be given until there is no clinical evidence of dehydration and until the urine approaches normal volume and specific gravity. Of course if hospital facilities are available more accurate methods of control should be exploited.

Nutrition may prove a very great problem. We have seen that the intestinal mucous membrane suffers early and severe damage. For this reason a bland diet, if possible, is indicated from the beginning. Neither the patient nor his attendants should be deceived by the relatively symptom-free latent period when a coarse diet of field-rations could aggravate the damage already inflicted on the gut. This consideration, however, should not be taken to imply that food of unsuitable texture should be withheld if none other is available. It is known from observations in the laboratory that animals fed immediately after radiation show more satisfactory survival rates than those that are starved. If anorexia is extreme or if the stomach cannot retain satisfactory amounts of food and drink, intravenous administration of saline and glucose becomes necessary. There appears to be no particular advantage in a high protein diet given by mouth, though this qualitative condition has been recommended.

At what time after exposure efforts to *anticipate or control infection* should be begun has not yet been decided. Further, beyond the fact that antibiotic therapy is the method of choice, no decision has been reached as to what particular agent or combination of agents should be used. A recommendation that has had wide acceptance is that penicillin in oil (400,000 units) should be administered intramuscularly every second day as a prophylactic measure, beginning on the third day. Penicillin, of course, has several disadvantages; it is not a "wide-spectrum" antibiotic, many persons have become sensitized to it and resistant strains of organisms may develop, so that this recommendation may be modified in the future. It should be remembered that suitably chosen sulfonamides may be valuable. If processes such as bronchopneumonia develop, anti-infection treatment must be reinforced and modified to combat the particular organism involved.

Control of the hemorrhagic manifestations of acute radiation syndrome is a complex problem, for the etiology is a multiple one—damage to capillary walls, inhibition of the humoral clotting mechanisms, platelet-depression, and the possible excessive production of heparin-like substances are among the factors suggested. The administration of fresh whole blood appears to be the best treatment for hemorrhagic manifestations but (in catastrophe especially) difficulties of supply would prove troublesome. Earlier writers have recommended the routine administration of whole blood at five-day intervals from the inception of the illness. This concept has been modified by other authorities who favor withholding blood until definite hemorrhagic signs become evident, and still others recommend administration of a single large transfusion—say 1,500 cc.—at the onset of bleeding. The supporters of these latter procedures consider that they will lessen the danger of undesirable reactions from repeated transfusions and that they will also decrease the unnecessary expenditure of badly-needed blood. It should be remembered that the present tendency is to recommend that the administration of blood should be withheld until hemorrhagic signs are definite; the appearance of a few purpuric spots or of a little melena in the third or fourth week of a mild case are not, for example, a strong indication for use of blood.

This survey should not close without laying stress on the importance of observational and expectant treatment. Considerations of medical manpower would demand that nurses, nurses' aides and other attendants charged with the hourly care of atomic bomb casualties assume grave responsibility and that they be watchful for early indication of radiation sickness. They should watch for characteristic symptoms and signs—loss of appetite, sores in the mouth, painful throat, nausea, loose stools, and melena. Sudden loss of scalp hair and gross ulceration of the buccal and pharyngeal structures are later and more obvious signs which anyone would notice; but attendants should know the earlier indications and observe carefully traumatic and thermal cases who "are not doing well"—in such patients radiation-injury can be a most serious complication at relatively low dosage levels and should receive prompt and thorough attention.

Though these remarks have been limited to the treatment of the effects of ionizing radiation inflicted on the organisms from a source outside it, a few words should be added regarding a second hazard, *viz.*, that of internal radiation. When a bomb is exploded at or near ground surface (low burst) there is produced heavy radioactive contamination of the ground itself. This activity continues for months and can be powerful enough in the earlier phases to inflict general damage by gamma emanations and skin burns by beta-particles. But the radioactive "dirt" can gain access to the body by ingestion, by inhalation, and through open wounds; and if the radioelements which gain access happen to be among those which (like plutonium, uranium, and strontium) tend to lodge in bony tissue, the long-term effects on the skeletal and hemopoietic systems can be serious indeed.

So far no satisfactory treatment for "internal contamination" has been devised. In animals the excretion rate of plutonium has been hastened and the storage rate in bone decreased, by administration of zirconium acetate and of complexing agents—*e.g.*, versene—soon after injection of the radioactive substance; but the present practical approach to this problem is entirely preventive. Ingestion must be prevented by avoiding the use of contaminated water and food; inhalation by use of respirators; and contaminated body surfaces cleansed by adequate measures at decontamination centres.

These principles could be applied at the various levels in the evacuation chain as follows:

For *first aid in the disaster area* it is recommended that the casualty be given rest and transportation to a first aid station. Anxiety should be allayed and fatigue and exposure avoided. Even the most trivial wounds should be protected against infection because of the patient's lowered resistance. Because of the effects of distance and shielding on the

size of the dose inflicted by an atomic burst, the *location* of the casualty should be noted accurately on the emergency medical tag.

At *first aid stations* vomiting should be controlled by Gravol or by other suitable drugs and electrolytes administered by mouth or intravenously if necessary. The recommended solution for intravenous administration is 5% glucose in normal saline and for oral use one teaspoonful of salt and one-half teaspoonful of baking soda to each quart of water. No fluids should be given by mouth to people with facial injuries involving the mouth or swallowing mechanism or to people with abdominal injuries. Sedatives may be indicated at this level, either orally, hypodermically or intravenously. Barbiturates will be available for oral administration and sodium pentothal for intravenous use. The casualty should be evacuated to a rest centre for observation as a lying or sitting case. If symptoms of radiation sickness develop at such centres he should be referred for medical treatment.

At *emergency hospitals* treatment for vomiting should be continued if indicated. Electrolyte solutions will be available and for urgent cases blood and plasma could be supplied. Barbiturates and sodium pentothal will be the available sedatives. If hemorrhagic signs develop whole blood can be given. Patients who have been exposed to radiation should be given 400,000 units of penicillin in oil (procaine penicillin G 300,000 units per millilitre with crystalline penicillin G 100,000 units) every second day, beginning on the third day. Later streptomycin or a broad-spectrum antibiotic (such as terramycin or aureomycin) can be added if necessary. These broad-spectrum antibiotics are considered to be interchangeable and will be available in 250 milligram capsules for oral administration. The recommended daily dosage of streptomycin is one gram intramuscularly, preferably in two doses.

SUMMARY

While some promise of specific therapy has been given by certain experimental approaches no such preventive or remedial treatment for acute radiation syndrome has been developed to the point of clinical application. For prevention we must rely on the physical principles of distance and shielding; for treatment on supportive measures applied according to the amount of radiation inflicted and (later) according to the patient's condition. Observational care is of great importance to casualties surviving atomic-bomb attack, all the more because the added insult of radiation injury may impede recovery or cause death in cases suffering from trauma or burns.

Destination: Nowhere!

THIS MONTH millions of pieces of mail will be carried by the post office. A great proportion of it will arrive safely. Unfortunately, quantities of it will wind up in the Dead Letter Office where a staff of clerks will spend hours — days — trying to find the correct address to which to deliver your good wishes, your loving gifts.

To ensure the safe arrival of everything you mail, here are a few simple precautions to take:

1. *Mail Christmas cards early.* All of them, excepting those for local delivery, should be in the mail by the time you are reading this.

2. *Print all names and addresses.* Your own handwriting may be perfectly legible to your personal friends but appears quite illegible to everyone else, including the postman.

3. *Check for correct postage.* Don't forget that all postage due is charged at double the original rate. Don't penalize your friends.

4. *Make sure packages are securely tied.* String too thin? Insufficient string? Granny knots? Lost parcels! Put Christmas seals in strategic places for double safety.

5. *Put your return address on all mail.* It is not necessary to write — excuse us, PRINT — either your own or the receiver's address on two sides of a parcel. It is simpler and just as satisfactory to put each on only once — preferably on the same side as you affix the postage. Use ink rather than a colored pencil for your printing.

Traitement du Syndrome Aigu des Radiations

LIEUT.-COL. F. C. PACE, C.D.

POUR LES FINS du présent article, on entend par maladie aiguë des radiations, le syndrome produit par la collision sur tout le corps d'émanations électro-magnétiques à grande puissance de pénétration, provenant d'une bombe atomique dans la première minute après l'explosion de cet engin de guerre. La collision de ces rayons *gamma* cause, tout d'abord:

1. Un trouble physique des atomes dans les éléments constitutifs de l'organisme.
2. Une série de troubles dans les mécanismes biochimiques et autres de l'organisme.
3. L'affection clinico-pathologique qui porte diverses désignations: maladie aiguë des radiations, mal aigu des rayons ou syndrome des radiations.

Ce syndrome, au point de vue clinique, est une maladie à trois phases. Dans la première phase, immédiatement après l'exposition et pour une journée ou deux après, surviennent des nausées, des vomissements, des malaises et de la diarrhée. La seconde phase est une période latente au cours de laquelle le malade se sent mieux et peut reprendre toute son activité pendant trois à dix jours. La troisième phase se manifeste par une fièvre en paliers, suivie d'anorexie, de vomissements, de diarrhée avec selles sanguinolentes, d'ulcération de la bouche et du pharynx, d'hémorragies sous-cutanées et pétéchielles généralisées, de dépilation du cuir chevelu, d'anémie, d'infections secondaires (souvent des voies respiratoires); la mort survient dans bien des cas entre la troisième et la sixième semaines. Les principales altérations histologiques sont la nécrose des tissus lymphoïdes et de la structure epithéliale; des avaries aux organes hématopoïétiques et aux cellules de la reproduction; et une lymphocytopénie primitive suivie d'une diminution du nombre de granulocytes et, à partir de la troisième semaine, une anémie aplastique.

Il existe quatre moyens de prévenir et de traiter ce syndrome. Ce sont:

1. L'élaboration de protection adéquate contre ces radiations.
2. L'emploi d'un traitement préventif spécifique administré *avant* l'exposition.
3. Le traitement spécifique *après* l'exposition.
4. Le traitement symptomatique et d'appui des symptômes et des signes après leur apparition.

Dans le présent état de nos connaissances, l'emploi des mesures de protection avant l'exposition et d'un traitement symptomatique spécifique après l'infliction de la lésion sont les seules méthodes qui aient quelque valeur pratique, et le traitement spécifique en vue de guérir la lésion fondamentale fait encore l'objet d'études expérimentales. Toutefois, parce que la recherche peut à un moment donné produire un agent spécifique de grande valeur clinique dans le traitement de ces cas, il peut être intéressant et utile de passer en revue quelques-uns des buts de la recherche qui se poursuit couramment sur les animaux, dans ce domaine.

On croit qu'un effet très fondamental des radiations ionisantes sur les tissus vivants est la production d'agents oxydants actifs tels que le peroxyde d'hydrogène formé à partir de l'eau contenue dans les cellules et les humeurs corporelles. Ces complexes oxydants réagiraient avec les groupes sulf-

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Le Lieut.-Col. Pace est membre du Service de Santé de l'Armée Royale Canadienne. Ceci est le septième d'une série d'articles du numéro spécial du *Canadian Medical Association Journal* sur la défense civile qui seront publiés avec la permission de l'Association Médicale Canadienne.

hydryl (SH) qui ont une telle importance dans l'activité de plusieurs enzymes; on a donc postulé que si l'on "tamponnait" ces radicaux SH par l'administration de composés contenant le même radical, on pourrait atténuer les effets des radiations. Quelques chercheurs, au moyen de composés tels que le glutathion et la cystéine, ont amélioré le temps et le taux de la survie, lorsque de telles substances avaient été administrées avant l'exposition.

Ce qui précède est un exemple des tentatives que l'on fait pour découvrir un pré-traitement spécifique. Voici un des post-traitements spécifiques: plusieurs chercheurs ont démontré que les radiations produisent certains effets semblables à ceux de l'histamine et ont découvert des niveaux élevés d'histamine dans le sang des animaux examinés. Le traitement avec des substances anti-histaminiques a permis d'obtenir une certaine baisse des taux de mortalité des animaux. Un autre exemple du traitement spécifique après l'irradiation est l'administration d'agents antihépariniques d'après la théorie voulant que les manifestations hémorragiques du syndrome sont attribuables à la production de quantités excessives d'héparine.

Une avenue de travail intéressante et prometteuse a été ouverte par l'observation que la nécrose, l'amincissement et l'ulcération de l'épithélium intestinal suivaient rapidement l'infliction de radiations sur tout le corps. Une telle lésion permet aux produits toxiques et aux organismes vivants de se frayer un chemin jusqu'à la circulation générale, en passant par la muqueuse intestinale lésée et, ainsi, de participer sérieusement à la symptomatologie, à la pathologie et au taux de mortalité du syndrome. On a constaté que l'administration d'antibiotiques qui enrayent ces infections améliorait les réactions des animaux et abaissait leur taux de mortalité.

Il semble bien établi que l'inhibition des fonctions des produits endocriniens du cortex surrénal contribue au tableau clinique de la maladie aiguë des radiations et on a signalé de bons effets obtenus par l'administration d'acétate de désoxycorticostérone et d'hormone somatotrope. On trouve de nouvelles perspectives dans les rapports qui parlent des avantages qui suivent l'injection d'extraits spléniques et de substance tirée de la moelle osseuse.

Les notes qui précèdent sont offertes non pas seulement à cause de l'intérêt qu'elles présentent mais aussi pour montrer que nous devrions être prêts à accepter des thérapeutiques spécifiques même si, pour le moment, nous ne pouvons en profiter à l'échelon clinique. Dans le domaine de la thérapeutique pratique nous avons six buts:

1. Le repos et les soins infirmiers.
2. Le maintien des équilibres des humeurs et des électrolytes.
3. Une nutrition adéquate.
4. Le contrôle de l'infection.
5. Le contrôle de l'hémorragie.
6. Le traitement de l'anémie. Toutefois, avant de considérer ces buts, nous devrions examiner les possibilités préventives offertes par les écrans et la distance.

Les écrans contre les radiations sont bien connus de tout médecin qui a vu un radiographe travailler derrière un écran de plomb. Toute substance, y compris l'air lui-même, possède une valeur d'écran spécifique contre les radiations électromagnétiques d'une bombe atomique. Cette valeur spécifique est exprimée en "demi-épaisseur" — c'est-à-dire, l'épaisseur d'une substance qui réduira de moitié la quantité de rayons qui la heurteront et la traverseront. La valeur "demi-épaisseur" d'une matière dense comme le plomb contre les rayons *gamma* est d'environ un demi-pouce; celle du béton, d'environ 3½ pouces, et celle du sable et de la terre, d'environ 7 pouces.

Les gens qui seront à l'abri dans les soubassements des maisons, dans des immeubles à murs épais ou même dans des trous creusés dans le sol, seraient protégés au moins jusqu'à un certain point contre les radiations ionisantes, peut-être assez pour qu'ils échappent à des blessures graves ou même à la mort. En plus de cette protection générale du corps, il reste possible d'assurer une protection locale des régions hautement sensibles aux radiations, telles le haut de l'abdomen; on a constaté que, chez les animaux, la protection

de la rate pendant la radiation était suivie d'une mortalité plus faible. Toutefois, l'auteur n'est pas prêt à exprimer une opinion sur la possibilité pratique de la protection localisée du corps.

La sévérité de la réaction clinique varie approximativement en raison de la dose infligée. Il est fort probable que la plupart des personnes qui subiront une dose de 500 roentgens ou plus de rayons *gamma* en une seule fois (c'est-à-dire, en une minute ou moins) mourront; que la moitié de celles qui subiront une dose de 400 R, de la même façon auront une chance de survivre mais, si elles survivent, elles seront gravement malades; que les gens qui subiront une dose variant entre 200 et 300 R seront malades, mais qu'un certain nombre d'entre eux mourront; que ceux pour qui la dose aura été de moins de 200 R mais de plus de 100 R seront légèrement malades tandis que les personnes qui auront reçu une dose de 100 R ou moins ne présenteront pas de symptômes de lésions. Il n'entre pas dans le sujet traité par la présente communication d'exposer les moyens possibles de calculer les doses, mais il faut noter deux points: (1) Que le moyen actuel le plus satisfaisant de déterminer la dose est d'employer des instruments d'une sorte ou d'une autre portés sur la personne même; (2) que les survivants non protégés au moment de l'explosion et qui se trouvaient à moins de 2,000 verges du point zéro du sol, devront être évacués même s'ils ne présentent aucune lésion thermique ou traumatique; tandis que ceux qui auront été à une distance de 2,000 à 2,400 verges n'auront probablement pas besoin de traitement.

Quelle que soit la façon dont on calcule la dose, les survivants à une dose de 400 R ou plus seront très malades et auront besoin d'un traitement précoce et complet. Le traitement des cas qui auront subi une dose plus faible devrait se donner d'après l'état clinique, mais il faut comprendre que des personnes ne présentant pas de symptômes après une plus faible dose, ne devraient pas être exposées de nouveau pendant des semaines ou des mois et même alors, seulement si les examens cliniques ou de laboratoire indiquent une santé normale.

Traitement

En ce point, nous pourrions examiner les buts du post-traitement d'appui et leur application aux cas présentant de la gravité à divers degrés.

Le *repos* doit être assuré dès le début pour tous les cas qui présentent des symptômes gastrointestinaux précoces, un malaise ou de la faiblesse. Il faut évacuer ces cas assis ou couchés, les aliter pendant au moins deux semaines et ne les renvoyer à leurs fonctions complètes qu'après un examen minutieux. Les cas qui présentent des symptômes plus graves doivent jouir d'un repos plus prolongé.

Le *maintien de l'équilibre des humeurs corporelles et des électrolytes* a beaucoup d'importance en présence de vomissements ou de diarrhée: de fait, les vomissements à eux seuls peuvent être le seul facteur qui cause la perte de fluides et de sel. On est donc justifié de prendre des mesures promptes en vue d'enrayer ce symptôme et l'on a proposé un emploi généreux, immédiatement après l'explosion, de médicaments tels que le Gravol, par les populations exposées, comme mesure opportune de traitement en masse. Toute victime qui a perdu beaucoup de fluides par vomissements ou diarrhée devrait se voir administrer des électrolytes par voie orale, ainsi que des solutions salines normales, des solutions de sel et de bicarbonate de soude ou des solutions de sel et de glucose; si ce mode d'administration ne peut être toléré, il faut injecter ces solutions par voie parentérale aussitôt que possible. Dans des circonstances critiques de désastre, il est peu probable que l'on puisse faire des tests précis de laboratoire et l'on propose donc que des solutions des types indiqués soient données jusqu'à ce qu'il n'y ait plus d'indices cliniques de déshydratation ou jusqu'à ce que l'urine atteigne un niveau normal de volume et de densité. Naturellement, si l'on dispose d'aménagements hospitaliers, il faut se servir de méthodes plus précises de contrôle.

La *nutrition* peut s'avérer un problème épineux. Nous avons vu que la muqueuse intestinale subit des atteintes précoces et graves et, par conséquent, il

est opportun de donner dès le début un régime d'aliments doux et ne laissant pas de résidus. Ni le malade, ni ceux qui le soignent, ne devraient se laisser tromper par la période latente relativement exempte de symptômes au cours de laquelle un régime grossier de rations de campagne pourrait aggraver le dommage déjà fait à l'intestin. Cette considération, toutefois, ne doit pas être prise comme signifiant qu'il ne faut pas donner d'aliments à texture inappropriée s'il n'y en a pas d'autres, car l'on sait, d'après des expériences sur des animaux, que ceux-ci survivent beaucoup mieux s'ils sont nourris immédiatement après l'exposition aux radiations que si on les laisse affamés. Si l'anorexie est extrême, ou si l'estomac ne peut garder des quantités satisfaisantes d'aliments et de boissons, l'injection intraveineuse de solutions salines ou glucosées s'impose. Il semble n'y avoir aucun avantage particulier à donner un régime riche en protéines, par la bouche, bien que cette condition qualitative ait été recommandée.

A quel moment après l'exposition faudrait-il s'efforcer *d'anticiper ou d'enrayer l'infection,* voilà ce qui n'a pas été décidé. De plus, outre le fait que la thérapeutique par les antibiotiques est la méthode de choix, aucune décision n'a encore été prise relativement à l'emploi d'un agent en particulier ou d'une combinaison d'agents. Une recommandation qui a connu de la vogue a trait à la pénicilline dans l'huile (400,000 unités) par injection intramusculaire à tous les deux jours, comme mesure prophylactique à compter du troisième jour. La pénicilline, naturellement, comporte plusieurs inconvénients: ce n'est pas un antibiotique à "spectre étendu"; plusieurs personnes y sont devenues sensibles et des souches résistantes d'organismes peuvent apparaître; cette recommandation pourra être modifiée à l'avenir. Il faut se rappeler que les sulfamidés bien choisis peuvent être utiles. S'il se développe des processus tels que la broncho-pneumonie, le traitement contre l'infection doit être renforcé et modifié de manière à combattre l'organisme particulier en cause.

Enrayer les manifestations hémorragiques du syndrome aigu des radiations est un problème complexe car l'étiologie est multiple: les avaries aux parois capillaires, l'inhibition du mécanisme de la coagulation humorale, la diminution du nombre des plaquettes, la possibilité de production excessive de substances semblables à l'héparine, sont parmi les facteurs mis de l'avant. L'administration de sang entier frais semble le meilleur traitement pour les manifestations hémorragiques mais (lors d'un désastre, particulièrement) les difficultés d'approvisionnement pourraient être cause d'ennuis. Des auteurs ont déjà préconisé l'administration courante de sang entier à intervalles de cinq jours à partir du début de la maladie. Ce concept a été modifié par d'autres autorités qui préfèrent attendre pour donner du sang jusqu'à ce qu'il y ait des signes manifestes d'hémorragie et d'autres encore recommandent l'administration d'une seule grande transfusion, disons, de 1,500 cc., au début de l'hémorragie. Les partisans de cette dernière méthode considèrent qu'ils atténuent le risque de réactions indésirables dues à des transfusions répétées et qu'ils diminuent aussi la dépense inutile de sang bien précieux. Il faut se rappeler que les tendances présentes sont d'attendre, pour administrer du sang, que les signes hémorragiques soient bien précis; l'apparition de quelques taches purpuriques ou d'un léger méléna dans la troisième ou quatrième semaine d'un cas bénin n'est pas, par exemple, un indice bien précis du besoin de sang.

Cette étude ne devrait pas se clore sans appuyer sur l'importance du traitement d'observation et d'attente. Les considérations de main-d'œuvre médicale exigeraient que les infirmières, les aides et autres préposés, chargés du soin des victimes d'un désastre atomique, assument de graves responsabilités et qu'ils surveillent avec grande attention, les premières manifestations de la maladie des radiations. Ils devraient guetter les symptômes et signes caractéristiques: inappétence, plaies buccales, mal de gorge, nausées, selles molles, et méléna. La perte soudaine des cheveux et l'ulcération grossière des structures buccales et pharyngiennes arrivent plus tard et sont des signes plus manifestes que n'importe qui peut noter; toutefois, les préposés aux soins devraient connaître les indices précoces et surveiller attentivement les

cas de blessures et de brûlures qui ne guérissent pas bien. Chez ces malades, les lésions par radiations peuvent constituer une complication des plus sérieuse à des niveaux de doses relativement faibles et ils devraient profiter d'une attention prompte et minutieuse.

Bien que les présentes observations se soient limitées au traitement des effets des radiations ionisantes infligées sur l'organisme par une source qui lui est extérieure, il faudrait ajouter ici quelques mots sur un second risque, celui de la radiation interne. Lorsqu'une bombe éclate au sol ou près du sol (explosion à basse altitude) il se produit une forte contamination radioactive du sol même. Cette activité se poursuit pendant des mois et peut être assez puissante au début, pour infliger des avaries généralisées par émanations *gamma* et des brûlures cutanées, par les particules *bêta*. Mais la "poussière" radioactive peut pénétrer dans l'organisme par ingestion, par inhalation, et par des plaies ouvertes; et si les éléments radioactifs qui pénètrent sont au nombre de ceux qui (comme le plutonium, l'uranium et le strontium) ont tendance à se loger dans les tissus osseux, les effets à long terme sur le squelette et les organes hématopoïétiques peuvent être réellement sérieux.

Jusqu'ici aucun traitement satisfaisant n'a été découvert pour lutter contre la contamination interne. Chez les animaux, le taux d'excrétion du plutonium a été hâté et le rythme d'accumulation dans les os diminué, par l'administration d'acétate de zirconium et de certains complexes tels le Versène, peu après l'injection de la substance radioactive. Toutefois, la façon pratique actuelle d'aborder le problème reste entièrement préventive. L'ingestion doit être empêchée en évitant l'absorption de vivres ou d'eau contaminés; l'inhalation, par l'emploi de masques, et les surfaces corporelles contaminées doivent être nettoyées d'après les méthodes reconnues, aux centres de décontamination.

Ces principes pourraient être appliqués à divers chaînons de la chaîne d'évacuation, comme suit:

Pour *les premiers secours dans la zone dévastée*, on recommande de faire reposer la victime et de la transporter ensuite à un poste de secourisme. Il faut calmer les inquiétudes et éviter la fatigue et l'exposition aux intempéries. Même les plaies les plus banales devraient être protégées contre l'infection à cause de la résistance plus basse du malade. A cause des effets de distance et d'écran sur l'importance de la dose infligée par une explosion atomique, *l'endroit* où se trouvait la victime doit être noté avec exactitude sur l'étiquette médicale.

Au *poste de secourisme*, les vomissements peuvent être enrayés au moyen de Gravol ou autre médicament approprié et des électrolytes administrés par voie buccale ou intraveineuse s'il le faut. La solution recommandée pour l'injection intraveineuse est du glucose à 5 p. 100 dans une solution saline normale et pour usage oral, une cuillerée à thé de sel et une demi-cuillerée à thé de bicarbonate de soude par pinte d'eau. Aucun liquide ne doit être donné à boire aux gens qui ont des blessures faciales qui intéressent la bouche ou le mécanisme de déglutition, ou aux gens qui présentent des lésions abdominales. Des calmants peuvent être indiqués dans ces cas, par voie orale, hypodermique ou intraveineuse. Des barbiturates seront disponibles pour administration orale, du pentothal sodique, pour injection intraveineuse. La victime devrait être évacuée sur un centre de repos pour observation comme cas couché ou assis. Si des symptômes de la maladie des radiations se manifestent à ces centres, la victime doit alors être confiée au médecin pour traitement.

Aux *hôpitaux improvisés*, le traitement pour les vomissements doit se continuer s'il y a lieu. Des solutions d'électrolytes seront disponibles et, dans des cas urgents, du sang et du plasma pourraient être fournis. Les barbiturates et le pentothal sodique seront les calmants mis en disponibilité. On peut donner du sang entier si des signes hémorragiques font leur apparition. Les gens qui ont été exposés aux radiations devraient recevoir 400,000 unités de pénicilline dans l'huile (pénicilline procaïnique G, 300,000 unités par millilitre avec 100,000 unités de pénicilline cristallisée G) à tous les deux jours, à partir du troisième jour. Plus tard, on peut y ajouter de la streptomycine ou un antibiotique à "spectre

étendu" (terramycine ou auréomycine), au besoin. Ces antibiotiques à "spectre étendu" sont considérés comme interchangeables et on pourra se les procurer en capsules de 250 milligrammes pour administration orale. La dose quotidienne recommandée de streptomycine est d'un gramme par voie intramusculaire, de préférence en deux doses.

SOMMAIRE

Bien que certaines techniques expérimentales semblent prometteuses d'une thérapeutique spécifique, aucun traitement préventif ou correctif contre le syndrome aigu des radiations n'a encore été élaboré au point qu'il puisse servir en clinique. Pour la prévention, on doit compter seulement sur les principes physiques de la distance et des écrans; pour le traitement, sur les mesures d'appui, appliquées suivant la quantité de radiations infligées et (plus tard) selon l'état du malade. L'observation est de grande importance dans le soin des victimes qui ont survécu à une attaque par la bombe atomique, d'autant plus que la lésion surajoutée par les radiations peut nuire à la guérison ou causer la mort des victimes de traumatismes ou de brûlures.

New Trends in Curricula for Schools of Nursing

JULITA V. SOTEJO

THIS SUBJECT OF NEW TRENDS has been to some degree disturbing since I am not certain that what might be reported in this paper as new is really new at all. That they could sound antique to countries where nursing is on a very high plane is not such a remote possibility. As a background, let us review for a moment previous efforts and contributions on the nursing school curricula. I should like to ask your indulgence over the fact that reference in this paper is made to the Philippines not because I wish to think of the nursing curricula of other countries less but that I know nursing education in my country better.

As nursing schools increased and nursing services expanded, education of the nurses which was originally the concern of the first few schools of nursing in the Philippines has become, in the face of growing problems, a matter of national study capable of being accomplished only by intensive cooperative planning and activity among nurses and persons interested in nursing. The first known attempt to standardize nursing curricula was in 1924, in the form of a small blue book of 234 pages published by the Filipino Nurses' Association. Unassuming in appearance, it was, nevertheless, a commendable piece of work representing the totality of thinking and efforts in the wake of handicaps which proved abundant in those formative years of our national history. With some degree of perfection such subjects as types of hospitals for training, requirements for admission, student health and recreation, number of admissions a year, length of nursing course, living conditions, undergraduate nurse-patient ratio, division of time for practice in the major services and affiliations with other hospitals, duties of the administrative and teaching staff were ably treated. The content of each lecture was briefly described, number of lectures to a course indicated, and the methods of teaching, consisting mainly of lecture, lecture-demonstration, laboratory, the clinical method, quiz and examination, were prescribed. Strange as it may seem, however, we fail to find the slightest reference to objectives either of the nursing schools, of

Miss Sotejo is dean of the College of Nursing, University of Philippines, and president, Filipino Nurses' Association.

the curriculum as a whole, or of the courses therein prescribed.

The years that followed brought several changes to this standard curriculum by individual schools of nursing. Courses were added, course hours increased on request, and a number of one-unit courses in bandaging, massage, ethics, personal hygiene, venereal disease, and others came into being. In spite of these supposed improvements, laymen, doctors and nurses alike felt that the graduate nurse "falls short in the application of technical knowledge in her relation with sick people due to lack of human understanding." The system of nursing education "lacked a definite orientation, instruction rather mechanical, too theoretical and highly technical, overloading the already overworked student."

Revision of the 1924 Standard Curriculum was on the way when World War II broke out. A new ideology, a new way of life was imposed on the Filipinos. Lives and properties were destroyed. Since people lived a day-to-day existence during those gloomy years, long-range planning in nursing was out of the question. Independence ushered in a new era, a new inspiration, a new life and, of course, new preoccupations that have usually besieged young nations to choose either survival or extinction. For nearly eight years nursing leaders have tried and are still trying, in the face of tremendous odds, to work on a revised nursing curriculum for the Philippines. The knowledge and experience of men in related fields are being brought in to contribute to sound education for nursing. The Bureau of Private Schools, the office responsible for accrediting private schools and colleges of nursing, has shown real and continuing interest in nurse education and provided the needed stimulation and leadership in improving present curricula for nurses.

The 1950 survey of nursing in the Philippines, sponsored by the Filipino Nurses' Association, should be credited for adding great impetus and inciting national or high-level consciousness anent the nursing needs of a war-devastated country. The recommendations in that report are about to be implemented, especially in providing adequate health facilities in rural areas and the much needed in-service education for all types of public health personnel. The impact of the results of this study on nursing in the Philippines is obvious since it pointed out more and more to nurse-preparing institutions the urgency of preparing nurses for service in rural communities where nursing service is a matter for urgent implementation. In 1951 when the standards of education in private schools became the target of security by the Senate (Congress of the Philippines) Committee on Educational Standards, nursing was again called, in the person of the Filipino Nurses' Association president, to evaluate its own type of education.

A very important factor that must be kept to the fore is the continuous influx of the latest trends in medicine, nursing, and public health from other countries, particularly the United States, through travel grants, scholarships and fellowships, and exchange professors — programs made possible by the Fullbright Act, the United States Public Health Service, the Rockefeller Foundation, the World Health Organization, and the Mutual Security Agency - Philippine Council for United States Aid. Thus we are assured of the introduction of new trends not only in the nursing curricula but also in nursing practice and in the medical and related fields of learning. Our problem lies in sorting out or discriminating which practices are and which are not applicable to local conditions in view of the underdeveloped national economy, the magnitude of local health problems, especially tuberculosis, beriberi, malaria, maternal and child health, and the prevalence of superstitious beliefs.

As a result of these events and in consonance with trends in nursing abroad, the following may be reported:

1. Schools and colleges of nursing are now attempting to define over-all educational objectives of the schools and of individual course offerings.

2. Acceptance of the necessity and the value of group work in curriculum plan-

ning under the leadership of the national organization.

3. Planning and conduct of programs for in-service education as a measure to promote professional growth in order to meet public health needs of the country and the educational needs of nursing schools.

4. Recognition of the value of liberal and cultural courses in the making of a professional nurse.

5. A definite trend toward the four-year integrated program and the rise of university schools of nursing.

6. Awareness of the fact that even a good curriculum could be ineffective if the nursing school is not provided with qualified staff and if there are not adequate physical and clinical facilities with which to administer it properly.

7. A growing consciousness among nurses of the need for an educational setting within which an educational program for nurses can best thrive.

8. Better planning for co-curricular activities intended to develop social skills of nurses.

9. Growing desire of graduate nurses to avail themselves of existing facilities for advanced nursing preparation.

10. A trend toward a democratic administration of nursing schools.

11. A trend toward better working conditions for nurses.

Within the curricula of nursing schools the following are in evidence:

1. Analysis of the relative values of types of experience and instruction with a view to developing the habit of critical thinking through problem solving.

2. A definite trend toward total care rather than just patient care through integration of the mental, social, physical, community and health aspects of illness in the major curriculum areas.

3. Developing awareness of and stimulating the utilization of community resources for the prevention and cure of illness.

4. Emphasis on the teaching function of the nurse and providing opportunities for experience in this activity during training.

5. Adoption of better and varied teaching methods and employment of various aids to learning.

6. Emphasis on correlation of theory and practice and providing adequate supervision.

7. A new emphasis on the need for sound interpersonal relationships.

8. Inclusion of academic and cultural courses which have been found useful for the development of the nurse as a person and as a nurse.

9. Redefinition of objectives and analysis of content with a view to facilitating learning. Introduction of new courses and experience designed to meet nursing needs of patients and families in rural and urban health work, experience in mental hospitals, and rehabilitation of the physically handicapped.

With this rather long enumeration of trends in the curricula for schools of nursing it is possible that I have created in your minds a generally favorable impression of what we have. Lest you charge me with misrepresentation of facts I wish to clarify by stating that what you heard are only trends and, therefore, do not represent typical conditions. The entire picture of nursing education is not altogether flawless.

We do have some very fine hospital schools of nursing but the majority of the schools are hospital schools originally established not as educational institutions, but as service units for providing cheap student nursing service for hospital patients. Not having any independent budget, the education of students is not often given precedence, hence the rotation through the different services is still based on the exigencies of the service. Very little supervision is provided in the hospital wards where students work, due to the constant preoccupation of the nurses to whom their clinical education is entrusted. Integration of health and social aspects of nursing and providing experience in public health nursing are still in the planning stage in most of our schools.

There is a dearth of adequately prepared nurses to take up teaching positions and positions of leadership in nursing schools, nursing service in hospitals, and an equally meagre supply of nurses prepared to go into staff positions in public health nursing — these in spite of the existence of

courses for graduate nurses in public health nursing and teaching in schools of nursing. The learning opportunities that psychiatry can contribute to sound nurse preparation are not being properly utilized.

There are, however, healthy beginnings that should not be left out which do not make the situation utterly hopeless. For one thing the Filipino Nurses' Association is active and capable of minimizing the commercialization of nursing education. Thousands of applicants seek admission to these schools which makes for improved and careful selection. The academic qualifications for entrance are gradually being stepped up so that only five hospital schools do not now require applicants to have one year of college work which includes such courses as general and inorganic chemistry, zoology, social sciences, English, Spanish, and psychology. A goodly number of medical men are gradually being won over to the need for better prepared nurses. Above all, many nurses are themselves, gradually albeit slowly, realizing that nursing schools should be truly educational in purpose, in set-up, and in machinery for administration, just like schools of law, medicine, engineering, and dentistry. In addition an important study is now being made with a view to assisting underdeveloped government nursing schools to improve their libraries, physical and clinical facilities, and raise the qualification of present teaching staffs.

Above all, the Philippines is not alone in this plight. Many of the countries in the Western Pacific Region have equally great if not greater health needs. With some of our neighbors the type of nursing education that most of us are familiar with is practically unknown; the problems of nursing education are, therefore, more complicated if not distressing. The nursing seminar sponsored by WHO in Taipei, Taiwan, last November, 1952, which 29 individuals representing 12 governments attended, has demonstrated one effective way of attempting the solution of nursing and nursing education problems through group cooperation and group thinking. Already the returned delegates have recognized such big orders as training nurses in underdeveloped areas, interpersonal relationships, curriculum planning based on local needs and goals, integration of the social and health aspects of the curriculum, and teaching methods. We, in the Western Pacific Region, are, therefore, happy that we are off to a good start in the solution of common problems.

Clearing Lung Debris

Surgical drainage in bronchitis, tuberculosis, asthma and other ailments may be obviated through the development of a new form of enzyme therapy in which a mixture of two enzymes is inhaled as a chemical fog to help clear debris from diseased lungs. While other enzymes are presently being used to dissolve debris they have to be injected. Enzymes used in the new procedure consist of a mixture of purified trypsin, a substance produced by the pancreas, and another enzyme called desoxyribonuclease, which is formed by living body cells.

Reporting on the new therapy at a meeting of the American Association for Thoracic Surgery in San Francisco, Calif., Dr. Seymour M. Farber, one of a group of San Francisco doctors who have experimented cautiously with the chemical fog, said that tests conducted thus far produced moderately favorable results in the majority of 24 patients but, he added, the treatment also caused undesirable side effects in two-thirds of the cases.

The chemical fog works directly on partially solidified accumulations of pus, mucus and other debris that clogs lung sacs but which is too thick to be dislodged by coughing. The enzymes cut these materials into thin substances which can then be expelled through coughing.

— Canadian Pharmaceutical Journal

Mountain Climbers' Paradise — Banff! Where we meet in June '54.

New Occasions

DOROTHY M. PERCY

New occasions teach new duties;
Time makes ancient good uncouth.
— JAMES RUSSELL LOWELL

IN THE YEAR THAT HAS ELAPSED since the presentation of the Structure Study at the biennial meeting in Quebec, there has been time for us to stand off to one side and consider its significance as a landmark on the road to true professional status. That it *does* mark a turning point in the development of our national association must be conceded even by those who do not find themselves in complete agreement with some of its recommendations.

It is not my intention to attempt a critical evaluation of the Structure Study. That is being done seriously and competently at provincial and district levels in preparation for full discussion at the next biennial. Rather I should like to set down a few observations as to how the proposed Structure appears to one member of the association who happens to be employed at federal level and who, accordingly, is accustomed to looking at things (if not always, at least frequently) from the national point of view.

In the first place it would seem that the Structure Study is *timely*. By that I mean it comes at a time when our national consciousness is emerging in clearer outline. Writers and speakers are articulate to the point of cliché concerning Canada's "growing pains."

These seem to have developed with peculiar intensity during and since World War II, although their "onset" can, of course, be determined much earlier in point of time. At all events evidence is not lacking that in many facets of her life Canada is emerging from the chrysalis of "local-mindedness" and that the degree of pain inherent in the process is in direct ratio to the significance of the ultimate goal.

Miss Percy is chief supervisor of nurses, Civil Service Health Division, Ottawa, Ontario.

Nurses employed at federal level are not entirely unaware or unappreciative of provincial problems, provincial differences, and provincial rights. It may be that, by virtue of their situation, they are actually more acutely aware of the implications of some of these than many nurses living and working in an individual province. On many occasions those at federal level are constrained to consider, not one point of view but eleven — ten provincial and the overarching national one. In other words they have to learn to use both ends of the telescope.

We know, for instance, that provincial autonomy has been, and will continue to be, the source of much of our strength and something to be guarded faithfully at all times. Nevertheless, we realize this same autonomy contains within it the seeds of our weakness and, unless we accept the challenge of our day to give more than lip service to the larger loyalty, progress to full status as a nation can be blocked or, at best, delayed.

It would seem, therefore, that the Structure Study, with its shift of emphasis, should strengthen the efforts of our membership to consider what, in nursing, is good not only for individual provinces but for the country as a whole. "The greatest good for the greatest number" can thus become more than a pious platitude, with realistic implications for all our thinking.

In the second place it occurs to me that the Structure Study demonstrates another aspect of timeliness. By its suggestion that "provincial people" no longer represent provincial associations *per se*, but should be free to vote as members of the C.N.A. from their respective provinces, it is putting a finger on *the responsibility of the individual nurse as a mature citizen*. It points up, to a degree not hitherto formulated, the onus there is upon her

for hearing, thinking, weighing and arriving at an independent opinion in the light of the evidence, regardless of local loyalties.

This would seem to be in line with much that has been stated recently in the professional literature both from within and without nursing. Everywhere stress is being laid on the obligation for all nurses to be competent not only in a narrowly professional sense but as citizens, first of their own immediate community, then of their province, their nation and, indeed, of the world. Through their membership in the I.C.N. and through the I.C.N.'s identification with WHO and other "islands of integration" on a global scale, nurses have unparalleled opportunities to think — and act — in terms of citizenship raised to its highest power.

Thirdly, the proposed Structure, with its greater degree of flexibility, and with its fresh emphasis on the importance of adequate communication, up and down and across, would seem to be preparing the ground for more practical cooperation of all levels of government in an attempt to solve some of the more knotty problems of nursing. We might as well confess frankly that the more difficult of these problems are too big for nursing itself. Whether we like it or not — whether government likes it or not — there will have to be a closer meshing of the various approaches to these problems. Some nurses would like to see more federal aid made available for nursing education — but "education" is a provincial responsibility! Is it utterly fantastic to suggest that with the new structure in operation the way may ultimately be cleared for arrival at a formula for the solution of some of our pressing problems, a formula that will be effective and acceptable, without sacrifice of anything essential?

These are difficult days for the profession. They are also days of challenge. There are new trails for the breaking, new horizons for those possessed of stout hearts for climbing.

In this coronation year we ponder the significance of the Crown as a link between the various members of the Commonwealth. In some way, perhaps not too clear even to ourselves at the moment, a phrase in use to describe this intangible but none the less real relationship might be applied to the thing we are striving to accomplish through the medium of a more efficient structure of our Canadian Nurses' Association — *Unity in diversity.*

Ideas for Christmas Floral Arrangements

Red and white Poinsettias around Santa Claus candle; graceful Arbor Vitae may be flecked or gilded.

* * *

Santa Claus boots with white Mums and Holly.

* * *

Miniature tree decorated with white Gardenias or red and white Camellias, underneath which is a skating scene (mirror, bits of sparkly cotton around the edge, and ice skating figures).

* * *

White Carnations, gilt Pine cones, and variegated Holly in bronze container; snow family candles.

* * *

Red Carnations, Pine, and candy canes criss-crossing in middle of arrangement; a red ribbon bow may hold the candy canes together.

* * *

Red roses, white Mums, and frosty candle in low container; red and gold ornaments add brilliance.

The Nurse in Rehabilitation

A. ZINOVIEFF, D. Phys. Med.

MEDICAL REHABILITATION can be defined as "the restoration of the handicapped, in the shortest possible time, to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

It is obvious that in such a comprehensive plan of management only teamwork can achieve success and it is not surprising that the team involved is quite a big one. It consists of two main groups:

THE REHABILITATION TEAM

Therapeutic Team	*Functional Team*
Nurse	Social service worker
Occupational therapist	Psychologist
Physiotherapist	Vocational counsellor
Speech therapist	Prosthetic appliance maker
	Clergyman

This team is, of course, under the direction of a doctor, who is responsible for the over-all planning and coordination of the program. This task is commonly that of the specialist in physical medicine and rehabilitation. As a rule only some of the members of the team are used in any particular case. Which they are will depend on the nature of the case.

Physiotherapy strives to restore any lost function such as diminished movement of joints, weakness of muscles, and loss of coordination. It is also used to relieve pain and improve circulation.

Occupational therapy likewise helps to restore function as well as to provide mental occupation. The latter is used specifically in the management of mental illness. The speech therapist, all too rare in Canada at present, is often helpful in speech disorders arising from cerebral palsy or a stroke. In the functional team the social worker provides valuable information and help with the family, social, and economic problems that arise so often. The psychologist may be called in for assessment of intelligence and for aptitude testing. The vocational counsellor helps with the placement of the disabled — often a very difficult task. The function of the prosthetic appliance maker is obvious. Lastly it is very important not to forget the contribution that a clergyman can make towards the spiritual welfare and strength of a patient, so vitally necessary in fighting against any adversity. It must be remembered that successful rehabilitation depends above all on the patient himself. If the will to get better is strong remarkable results can be achieved.

After this preliminary and brief account of the part played by the other members of the rehabilitation team, some detail of the part played by the nurse can now be discussed. The nurse has certain advantages over the other members of the team. In hospital she sees and treats the patient before, often long before any of the others are called in. Initially the problem is often one of saving life or of urgent medical or surgical treatment. Even from the beginning, however, just as the good physician or surgeon thinks in terms of the end result, so must the good nurse. This is all too often forgotten,

Dr. Zinovieff, until lately director of the Division of Physical and Occupational Therapy at the University of Toronto, is now director of physical medicine at Shotley Bridge Hospital, Durham, England.

so that small things are left undone that ultimately make a difference to the speed or completeness of recovery. Besides the important psychological effect that a nurse has on every patient, there are also physical aspects of rehabilitation. Some examples will illustrate these points:

On the neurological wards how often will a nurse remember that deformity of joints must be protected against in a paralyzed patient from the very beginning by suitable placing of the limbs in bed? Thus a patient with a potential foot drop should always have a foot-board and cradle. Otherwise a fixed equinus deformity is certain and this will ultimately make walking difficult. The frequency with which such a deformity is seen suggests that the required attention is all too often lacking. On the arthritic wards great care is required in nursing affected joints in such a way that not only pain is relieved but deformity prevented. The nurse must play her part in this — it is not solely the doctor's or physiotherapist's responsibility.

In traumatic cases rehabilitation begins as soon as the fracture is set or surgery completed. Hourly exercises are often prescribed for the patient to maintain or restore movements or muscles. While this task is mainly the physiotherapist's, the nurse can help a great deal. She is on the ward for a greater part of each day than the physiotherapist and so should encourage the patients who have to continue their hourly exercises themselves. In this way she helps the patient and also contributes her full share of the teamwork in his rehabilitation. All too often, unfortunately, one sees nurses who do not interest themselves in such things. Perhaps they feel that it is not really their business but it is very much so. There is no place for parochialism in good teamwork. Some overlapping is bound to occur.

On the general surgical wards, especially after abdominal operations, the nurse will always turn the patient regularly to look after his skin but how often will she remember at the same time to make him cough while supporting the incisional wound with his hand? If by doing so she will prevent even a few patients out of every hundred from getting a pulmonary collapse it is worthwhile.

These are only a few examples from very many of how a nurse can help beyond her routine work. In every field there is some special problem of management with which the nurse should be familiar if the best results are to be obtained. One often hears of nurses complaining that their work is too much concerned with chores and too little with the treatment of the patient. By studying thoughtfully what she can do to help in rehabilitating a patient, she can put new life and greater interest into her work.

The nurse, however, contributes to rehabilitation not only on the hospital wards but also in her work on home service. Here she is in an excellent position to find cases that need rehabilitation and refer them to the correct agency. The more she becomes aware of the total problem of rehabilitation, where it can be expected to succeed most and the means employed in achieving it, the more value will she be to her profession and to the community. Every member of the rehabilitation team should have a reasonable understanding of the work done by the other members. Only then can the fullest cooperation be achieved. It is such cooperation that distinguishes the best rehabilitation centres. In them, not only is there enlightened and dynamic direction but also perfect teamwork. In this every member of the team knows exactly what part he or she plays in the process and all professional jealousy is forgotten in the objective for which every member of that team is striving — to get the patient well as quickly as possible.

The old saying "Feed a cold and starve a fever" isn't compatible with modern medical belief. A cold should be treated with plenty of liquids and bed rest, if possible.

Institutional Nursing

Why Bother with Medical Records?

SISTER MARIE ST. PIERRE, s.g.m., R.R.L.

IMPORTANCE OF MEDICAL RECORDS

REGARDLESS OF THE SIZE and location of any hospital, its primary function is the proper care of the sick and injured. One of the essentials for the fulfilment of this function is the medical record, the content of which, if adequate, may not only lead to proper diagnosis and treatment of a specific case, but assist in the subsequent care of other similar cases. The medical record also aids the hospital in its secondary functions and it is of legal value.

"Every illness," says Dr. McEachern in "Hospital Organization and Management," "even though it be of a minor character, involves such extensive study and examination of the patient that it is utterly impossible for all of this detail to be carried in the mind of any individual. In order that the information gained may be accurately available, it must be recorded."

The value of medical records will, therefore, depend on the thoroughness and accuracy with which they are compiled. It must be remembered that medical records do not just happen: they are the result of the combined efforts of the hospital authorities, the medical practitioner, and the nursing personnel. Hence, no one can shirk responsibility for finding ways and means of securing and preserving good clinical and nursing records.

WHAT IS A MEDICAL RECORD?

It is a systematic compilation of data pertaining to the patient's illness or condition, sufficient in degree to justify the diagnosis, to warrant the treatment, to show the progress of the case and to state the end results. It is composed of three major sections: The Identification Section, the Medical Section, and the Nurses' Section.

Sister St. Pierre is director, St. Boniface (Man.) Hospital School for Medical Record Librarians.

IDENTIFICATION SECTION

This includes information collected upon admission, the purpose of which is to identify the patient and his case record. This is usually noted on the face or summary sheet of the medical record, on the patient's index card, and in the patient's register.

MEDICAL SECTION

The information assembled here is collected by or under the supervision of the attending physician. It comprises:

1. The history under the following headings:

(a) *Chief complaint* — or the cause that prompted the patient to seek medical advice and treatment.

(b) *Family history* — or history of inherited tendencies which may have a bearing on the present illness.

(c) *Past history* — or summary of previous illnesses, operations, accidents, etc., and any data which may in any way be related to the present complaint.

(d) *History of present illness* — date and manner of onset, duration; subjective signs; symptoms of diseases, injuries, etc.

2. Functional inquiry or review of systems.
3. Physical examination.
4. Provisional diagnosis.
5. Special examinations: x-ray, laboratory, O.R. reports, etc.
6. Progress notes.
7. Final diagnosis (with secondary and associated conditions and complications).
8. Condition on discharge.
9. Follow-up.
10. In case of death, autopsy findings.

The physician's orders must always be recorded in writing and signed by him. It must also be remembered that the attending physician is responsible for the record as a whole. In fact, he assumes this responsibility in affixing his signature of approval on the summary sheet.

Special reports call for special attention. *Accident or casualty reports* should be made out whether the injury is serious or not. How, when and where the accident occurred is most important. The following outline may be of assistance in recording accident data:

1. Identification of patient — date.
2. Place of accident.
3. Manner of occurrence — time.
4. By whom the patient was injured.
5. Manner of conveying patient to the hospital — whether walking, carried, by ambulance or other means.
6. Name of person supplying information.
7. Witnesses.
8. Nature and extent of injury.
9. Treatment (if antitoxin was given, by whom and when).
10. Diagnosis.
11. Disposition of the case.
12. Note stating whether relatives were notified or not.
13. Name of nurse caring for the patient.
14. Signature of attending physician.

Clinical laboratory tests should not only be done but recorded, as they play an important role in the diagnosis of any given case. Proper treatment may depend on the accuracy of laboratory reports. This should be a matter of great concern to the head nurse.

Operative reports need to be very complete. Most hospitals have adopted the policy of having a written authorization for operation on all surgical cases. This is a safeguard to both hospital and surgeon. The authorization should be signed before sedation is given preparatory to surgery.

(a) *The anesthesia report should show:*

1. Identification of patient with date.
2. Pre-operative medication given and the amount.
3. Type of anesthesia given.
4. Duration of anesthesia.
5. Medication given in operating room.
6. Condition of patient throughout operation.
7. Signature of anesthetist.

A complete history and physical examination, particularly of the heart, lungs, mouth, nose and throat; temperature, pulse, respiration, blood pressure; reports of urine, blood, etc., should be on the chart before administration of anesthesia.

(b) The *operative report* should record:

1. Identification of patient with date.
2. Pre-operative diagnosis.
3. Type of incision used; method of separating muscle tissue, etc.
4. The technique used in surgery, ligatures, etc.
5. Operative findings (with description of normal as well as pathological findings).
6. Type and number of drains and packs used.
7. Sponge count.
8. Method of closure of operative wound.
9. Type of suture material used; tension sutures, if any.
10. Names of assistant, instrument nurse, and sponge nurse.
11. Signature of surgeon.

Removal of sutures, packs, drains, etc., as well as condition of wound must be recorded. Some hospitals use a dressing room record; others require this information on the progress notes or the graphic sheet and nurses' notes. Whatever system is adopted, this cannot be overlooked.

All reports must bear proper identification data, should be dated and signed. Initials only are not acceptable.

Nurses' Section

This section is composed of the graphic sheet, the diet, treatment and medication sheets. One sometimes wonders how many nurses realize the value of their contribution to the medical record. The bedside report implies expert observation.

Accurate and complete clinical recording is an extension of efficient bedside nursing, and ability to do such re-

cording is a qualification of the efficient nurse . . . Clinical recording requires accuracy, promptness in reporting developments, and careful itemization of services performed in carrying out the physician's orders for the welfare and comfort of the patient. The same nurse is not constantly on duty during the day and night. One who has observed an important development may be off duty or attending another patient at the time of the physician's call or she may forget about the observation entirely. This is why every important observation must be recorded. The entire plan of treatment may depend on the information recorded, and even though the physician visits the hospital but once a day he should be able to watch his patient's progress with the help of intelligently recorded bedside notes. — HUFFMAN'S MANUAL FOR MEDICAL RECORD LIBRARIANS.

I will not attempt to discuss with you what should be recorded nor how it should be recorded but I would like to point out that care should be exercised in recording the following which are sometimes neglected:

Proper identification of patient.

Date, hour, and method of admission and discharge.

Condition of patient at the time of admission and discharge, with signature of the nurse responsible for these procedures.

Continuity and completeness of daily bedside notes.

Notation of any abnormalities, such as bedsores, redness of skin or wounds, etc., upon admission or developed during stay in hospital, burns especially.

Removal of sutures, drains, packs, etc.

Hypodermic or intramuscular injections should indicate region.

All treatments requiring aseptic technique should be followed by the signature of the nurse.

The foregoing, I believe, summarizes the most important data which make up the medical record. One may be tempted to ask: How may this be done in a small hospital? As an example, let us consider the actual situation in a 14-bed rural hospital staffed with one night and two day nurses, besides two or three other persons for various duties. One nurse, who is very keen, manages to assemble both administrative and medical records in addition to her nursing duties. Her record consciousness is such that she obtains adequate medical records, history included. She herself records as much of the history as possible; this is completed, sometimes corrected, by the attending physician (the only local doctor). When she called on me for advice, her problem was to devise a method of preserving medical records in such a way that they would be accessible to the physician upon readmission of patients.

PRESERVING MEDICAL RECORDS

This can be done when records are filed and indexed. Numerical filing is the most common method used by hospitals. It lends itself to either the Unit System or the Serial System of numbering records.

Under the *Unit System*, the patient is assigned a number on his first admission and this remains his number for all subsequent admissions. This is most suitable in a hospital situated in a locality with a stable population or in a hospital where patients, with chronic illnesses, return repeatedly.

Under the *Serial System* the patient is given a new number on each admission. This system is suitable in a hospital where a large number of acutely ill patients are usually treated for one illness only.

The *Serial-Unit Numbering Method* provides a unit record even though a unit number is not used. With this method all previous records are brought under the latest number on each readmission. A marker, usually the original folder, is left in the file to indicate the new number of the chart, thus providing a way of finding the record in case a previous number is all that is at hand.

The Patient's Index Card bearing the *number of the chart* is the key to the *numerically filed chart*. A 3 x 5 unit card will carry all the necessary information for as many as 12 admissions.

Contents of Card

Name and age of patient

Address

Attending physician
Date of admission
Date of discharge
Chart number

The method of procedure is rather simple. If the Unit System is used, an index card is made for every new patient. For readmissions, the previous card is pulled out and the date of readmission is typed in. During the period of hospitalization, the patient's index cards may be filed alphabetically in the in-patient file. Upon discharge, the discharge date is recorded and the card is placed back in the Permanent Index File also known as the Master File.

The principles of medical record keeping constitute the subject matter of a 12-month course. The whole theory cannot, therefore, be imparted in just one paper. Many important points will necessarily have to be left out, such as the diagnostic and operative indexes through which medical records are made available for statistics, study and research. It is felt, however, that a short discussion on the confidential character of the medical record should find a place here.

Use of Medical Records

The medical record is a confidential and privileged communication which must be safeguarded from unauthorized inspection. A basic knowledge of the different phases of its use as a personal or as an impersonal document is necessary, as extreme care and caution should be exercised not to divulge information.

Personal document: The medical record is used as a personal document when its use is associated with an individual patient, as for: Treatment of the patient himself in present and future illnesses; in medico-legal action; when it is used by compensation carriers, insurance companies, etc. In the latter cases a written authorization, signed by the patient himself, must be obtained before information is released.

Impersonal document: The medical record is used as an impersonal document when its use is not associated with a particular individual — e.g., in the compilation of statistics; research for scientific investigation; case study by interns or nurses.

Conclusion

Medical records are kept primarily for the benefit of the patient in present and future illnesses. If adequate, the medical record is of value for proper diagnosis and treatment in present illness. In future illnesses, a patient's life may be saved if previous records are made available in time of emergency; time and expense may also be saved as other tests need not be repeated.

The medical record is also kept for the protection of the hospital and physician in medico-legal cases: unless accurate and complete, it can only be damaging to both hospital and doctor. Through accurate and complete medical records, patients receive better care; physicians augment their clinical knowledge; hospitals can estimate care patients receive and determine reasons for results; the cause of medical science, so valuable to public health, is benefited through study and research.

The objective of the Victorian Order of Nurses has always been the welfare of both the patient and his family. The Victorian Order nurse's aim is to leave the patient and family a stronger and more united group, better able to cope with future health problems as a result of her service to them. She recognizes and respects their own capacity to bring about a return to health for the patient and the family unit, both of which are affected by the illness of one member. She sees her role as one of encouraging the patient and those who are close to him to use the resources that lie within themselves to promote healing. A nurse can do no more, for fundamentally these are the forces which heal the sick and maintain a wholesome life. Her bed-baths, back rubs, hypodermic injections and other treatments are aids to this end. The support she is able to convey to the patient and family while she is giving care helps them to find their own powers to overcome disease or adjust to a permanent disability. — A.I.B.

Trends in Nursing

The Nurse's Function

WITH THE MANY periodicals and pamphlets that flow into National Office with every mail, quite a problem arises as to which is the most important — to get on with the various pieces of work at hand or to settle down to read for awhile. Sometimes, though, a happy compromise can be made for out of the reading often comes the solution to a knotty problem.

Today we are searching our minds for the answer to that vital question — "What is the function of the professional nurse over and above the physical care of the patient?" In the publication Davis' *Nursing Survey* for October, 1953, there is an abstract "The Cancer Nurse" from the *Cancer News*. Here are a few paragraphs:

> With more and more patients with cancer being cared for at home, the public health nurse has an increasingly significant role. Not only must she be thoroughly aware of all the methods with which the physician has treated the patient so as to be able properly to interpret his orders, but she must be a morale builder for patient and family as well. To explain in simple language what the doctor plans for the patient so that both patient and family will cooperate fully is a job which the nurse does in a friendly, warm manner. She is able to show the family how to handle the patient, encourage them to create as nearly normal a home setting as possible, and by her attitude and example build an atmosphere of optimism and hope. All this while she is carrying out her professional role in administering to the patient, helping him to help himself, and reporting progress to the doctor.
>
> In the case of cancer of the breast, for instance, the nurse can do a great deal in assisting the patient by suggesting ways in which to exercise through simple normal activities — as for example the combing of hair. There is a close correlation between most of the exercises involved and many of the household tasks which most women normally perform. Basic exercises may, therefore, be abandoned as soon as household activities can be substituted.
>
> This type of aid to the patient, of course, is not confined alone to those being treated at home. Certainly, the hospital nurse can and does do a great deal to aid the patient before leaving the hospital. Helping the patient over the first fears and awkwardness of an artificial limb and other prostheses is invaluable to his future well-being. Teaching of colostomy patients in the use of an irrigator is also a case in point.
>
> It has been said that if cancer control is to make the progress so urgently called for, the nurse will have to assume more and more responsibility as a community-minded citizen for the development of broad cancer education programs among the general public. Any nurse, whether in industry, public health, hospital, or other situation — wherever she is in contact with people — can be an effective crusader for early recognition of danger signals leading to early diagnosis and treatment.

Although this excerpt applies to nursing in relation to cancer, still it can be interpreted in the light of many other disease conditions. The professional nurse is expected to have the skills, the knowledge, and the ability to use or direct the use of these for the benefit of the *individual* patient. It is the uniqueness of each patient that is the challenge to our profession.

Press Clippings

For several years the C.N.A. has subscribed to the Canadian Press Clipping Service. Those news items which are of interest to nurses across the country are mimeographed and distributed to the provincial associations. It is not always possible or wise to include some which indicate a very limited knowledge of facts about nursing. We were particularly interested to read a series of "Letters to the

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These notes are prepared by a member of the National Office staff of the Canadian Nurses' Association.

Editor" which started with a tongue-in-cheek note about the education needed to enter nursing, was misinterpreted and, without a doubt, gave misleading information to the readers.

It so frequently happens that a small, inconspicuous item is commented upon by one reader, draws the interest of others, and ends by influencing more people than it could possibly have done in its original form. The moral seems to be, leave well enough alone as long as the issue is not vital. Or, better still, counteract it with authenticated information from an official source in a *separate* news release.

Banff in '54

When we first started planning for the 27th Biennial Meeting of the C.N.A. at Banff, it seemed so far in the future that there was a feeling of unreality about the arrangements. Not so now! When this column appears in *The Canadian Nurse,* there will be less than six months before we board the special train. Banff, now covered with snow and welcoming the skiers, will have shed its blanket in June and be emerging in its endless variety of colors. If you wish a foretaste of what you will see, try to view the film "Shining Mountains."

Greetings!

National Office wishes to extend to all the members of the C.N.A., and their friends and colleagues, its very best wishes for the Christmas season. Although many nurses have to be on duty on Christmas Day, they, too, have the feeling of this festive season. How much harder it would be if our work was entirely away from people!

Merry Christmas!

Orientation et Tendances en Nursing

LE ROLE DE L'INFIRMIERE

TOUS LES JOURS lorsque le courrier nous apporte de nombreuses revues et des dépliants, le même problème se pose à notre esprit — quelle est la chose la plus importante à faire? continuer le travail en marche ou l'arrêter et lire un peu. Un compromis peut amener un résultat inattendu: souvent au cours de ces lectures l'on trouve la solution d'un problème épineux.

Aujourd'hui nous cherchions la réponse à cette question importante: Quel est le rôle de l'infirmière? Dans la revue *Davis' Nursing Survey* du mois d'octobre 1953, il y a le sommaire d'un article "L'Infirmière et le Cancer," publié dans le *Cancer News.* En voici quelques paragraphes:

"Le nombre de cancéreux traités à la maison étant toujours plus grand, l'infirmière visiteuse a un rôle plus important à jouer. Non seulement elle doit connaître toutes les méthodes dont le médecin s'est servi pour soigner le malade, afin de bien interpréter ses ordres, mais elle doit être capable de remonter le moral du malade et celui de sa famille. Elle doit, dans un langage simple, d'une manière sympathique et aimable, expliquer les plans établis par le médecin pour les soins à donner à son malade afin que lui-même et sa famille y coopèrent entièrement. Elle doit être en mesure d'enseigner aux membres de la famille comment s'y prendre avec ce malade, les encourager à maintenir la marche de la maison aussi normale que possible, et créer par son exemple et son attitude une atmosphère d'optimisme et d'espérance. En plus de donner des soins elle doit aider le malade à s'aider lui-même et elle doit apporter au médecin son état de santé.

"Dans un cas de cancer du sein, l'infirmière peut aider sa malade à faire les exercices prescrits en lui faisant accomplir des besognes quotidiennes normales — par exemple, se peigner. Souvent les exercices prescrits peuvent être remplacés par des tâches qui se font normalement tous les jours à la maison. Les exercices fondamentaux peuvent alors être remplacés par des tâches quotidiennes qui demandent le même effort.

"L'infimière doit aider de la même façon tous les malades, non seulement les can-

Ces notes sont préparées par un membre du Bureau National de l'Association des Infirmières Canadiennes.

céreux traités à la maison. L'infirmière à l'hôpital fait beaucoup pour son malade avant son départ de l'hôpital. Aider le malade à surmonter les craintes et l'embarras que cause un membre artificiel ou autre prothèse est d'une valeur inestimable. Enseigner à un malade, ayant subi une colostomie, comment se faire une irrigation est un autre exemple frappant de l'aide apportée.

"Il a été dit que si la lutte contre le cancer doit progresser en raison de la diffusion de la maladie, l'infirmière devra assumer plus de responsabilité dans les campagnes d'éducation du public. C'est là son rôle de bonne citoyenne. Toute infirmière, qu'elle soit dans l'industrie, en hygiène publique, dans les hôpitaux ou ailleurs peut, dès qu'elle rencontre le public, lutter contre le cancer en signalant tout ce qui peut conduire à un diagnostic prompt et à un traitement précoce."

Bien que les lignes qui précèdent s'appliquent au cancer, les mêmes remarques peuvent être faites concernant d'autres maladies. L'on s'attend à ce que l'infirmière professionnelle applique ses connaissances, son habilité, au bien-être de chacun de ses malades. Le malade actuel est toujours le centre de notre intérêt — c'est là le côté passionnant de notre profession.

Coupures de Journaux

L'Association des Infirmières Canadiennes, durant plusieurs années, s'est abonnée à une agence de presse afin d'obtenir des coupures de journaux sur ce qui concernait les infirmières. Ces coupures étaient polycopiées et distribuées aux associations provinciales. Il n'était pas toujours sage de tout reproduire — tant de gens ne sont pas au courant des faits concernant le nursing. Une série de lettres sur l'instruction nécessaire à une étudiante infirmière fut envoyée au rédacteur en chef d'un journal à la suite de remarques faites ironiquement et mal interprétées par le lecteur.

Il arrive fréquemment qu'un lecteur donne une grande importance à une chose relativement banale et attire de fait l'attention d'un grand nombre. La morale à tirer semble celle-ci: Pourquoi faire de la publicité aux choses sans importance ou encore mieux se renseigner à la source et faire paraitre les renseignements dans les journaux.

Banff — 1954

Lorsque nous élaborions les projets du 27e Congrès de l'A.I.C. à Banff, cela nous semblait un rêve. Il n'en est plus ainsi. Lorsque cette chronique paraîtra nous pourons dire: dans six mois nous serons à bord du train spécial en route pour le Congrès. Banff, couvert de neige, invite les skieurs. En juin, dépouillée de son manteau de neige, elle nous apparaîtra toute resplendissante de couleur. Le film "Shining Mountains" nous donnera une idée de cette splendeur.

Meilleurs Voeux

Le Secrétariat National désire offrir à tous les membres de l'A.I.C. et à leurs amis et collègues leurs meilleurs voeux. Bien des infirmières travailleront durant les Fêtes mais elles ne se sentiront pas seules. La sympathie de leur entourage sera communicative. Combien plus à plaindre sont les personnes qui travaillent hors des gens!

JOYEUX NOËL!

By *Chuckles, P.R.N.*

The ear is one of the most delicate and dangerous organs; it must be handled with the utmost care.

The two layers of the skin are: ditimus and epiditimus.

The functions of the spinal cord are: (1) to act as a water bed; (2) to aid in lumbar puncture; (3) to give prominence to the backbone.

An embolus is the smallest unit of a cell.

Meconium is the degeneration of the intestines of the baby.

Mastitis is a condition of inflammation in the parts used to masticate food.

Puerperium — a term used in obstetrics to refer to the perineum of pregnant women.

The glomeruli are minute tufts of capillaries located in the helium of the kidney.

Man has a common destiny in his inevitable rendezvous with death. As he proceeds through life three things are necessary: Something to do, someone to love, something to hope for. This formula for living can be applied to all races and creeds the whole world over.

— Rupert King

ALBERTA NURSES look forward with pleasure to being your hostesses at the Biennial Meeting in Banff, ***June 7-11, 1954,*** and have many plans afoot for your entertainment.

For those of you who arrive on ***Sunday,*** special church services have been arranged. For the Roman Catholic members, several masses are planned and for the Protestant members, evening services will be held at the Presbyterian, United, Anglican, and Full Gospel churches. Sunday should also afford you an opportunity to do some sight-seeing on your own.

Photo by John McGinnis

Chuckwagon dinner

Monday evening a Chuckwagon Dinner will be held at the Banff Springs Hotel. This event, which will be strictly informal, is planned early in the Convention Week to give everyone an opportunity to greet friends, old and new. Appropriate entertainment will go along with the dinner so get out your ten-gallon hat and dirndl skirt and get into the swing for a real, old-time, western evening.

Tuesday and Thursday afternoons and evenings have been left free for unscheduled activities and trips. Would you like to visit the Banff Chair-Lift? or Johnson's Canyon? or Lake Louise? These are included on the several tours that have been arranged by your Transportation Subcommittee. Special rates have been offered for those who would like to take a launch trip or go on a riding party. Excellent swimming, golfing, and mountain-climbing facilities are available. Films will be shown at the hotel both evenings. You could take advantage of these free times to plan alumnae get-togethers. The Entertainment Sub-committee would be pleased to give you suggestions but, in any event, please clear any special gatherings through us to avoid overlapping plans.

On ***Wednesday evening*** a buffet supper has been arranged in the auditorium of the Banff School of Fine

C.P.R. Photo

Mt. Stephen Hall, Banff Springs Hotel

Arts for all student nurses attending the Convention. Later that evening, the students are planning a program in the Banff School auditorium to which the general membership is invited.

The Nursing Sisters' Association biennial meeting will be held on ***Thursday afternoon*** in the Banff Springs Hotel. Their meeting will be followed by a reception and banquet at Mount Norquay Lodge.

Our final get-together will be on ***Friday evening*** after the Mary Agnes Snively Memorial Lecture and the installation of officers. The Alberta Association of Registered Nurses will welcome you at a coffee party in the View Lounge of the Banff Springs Hotel.

We hope that the natural splendor of Banff, associated with a fine program and the sincere spirit of hospitality that awaits you, will make the 1954 Biennial Meeting a memorable occasion in your professional careers.

Great things are done when men and mountains meet. — WILLIAM BLAKE

JEANIE S. CLARK
Entertainment Sub-committee
C.N.A. Arrangements Committee

Guardian

When it is necessary to employ a baby-sitter to guard a small child during the parents' absence, the greatest care should be taken to ensure that the person chosen is reliable and able to take care of a youngster or infant, even if only for a few hours. Many teen-agers are trustworthy and experienced in helping with the children in their own families, while others would not have the same sense of responsibility. Even older persons are not always the most desirable types for this work. Parents should be quite sure that the sitter is not suffering from a cold or any contagious respiratory ailment, since such conditions may be much more serious for young children than for older people. In some communities, there are agencies which sponsor reliable baby-sitters whose character and health are ascertained before they are employed.

Nursing Profiles

Florence Lillian Campion has joined the staff at the National Office of the Canadian Nurses' Association in Montreal as secretary of nursing service.

Born in England, Miss Campion received her education in Toronto and graduated from The Wellesley Hospital there. After taking post-graduate work in obstetrics at the Royal Victoria Montreal Maternity Hospital, she returned to her home school as night supervisor. She became an instructor at W.H. after completing the course in teaching and supervision at the University of Toronto School of Nursing. In 1946 she took time out to attend Teachers College, Columbia University, where she secured her B.Sc., adding the M.A. qualification in 1951. She has been associate director of nursing service at the Kitchener-Waterloo Hospital, Kitchener, Ont., for several years.

The position that Miss Campion has recently accepted is a new development in the progress of professional nursing in Canada. Eminently qualified to give leadership in this direction, Miss Campion will work with others to promote a high standard of nursing service wherever it is required — in hospitals, homes, public health nursing organizations, and industry. She will be prepared to make such studies of nursing service problems as may present themselves.

Frances U. McQuarrie, who has been assistant secretary in National Office for the past 15 months, is taking over new responsibilities as secretary of nursing education with the C.N.A.

The appointment of two such capable nurses to these very essential posts in a rapidly expanding professional organization augurs well for future developments in nursing in Canada. They will become familiar to nurses in every part of Canada as they administer their respective activities in this enlarged program.

Nakash, Montreal

F. Lillian Campion

Frances U. McQuarrie

Margaret O. Cogswell has joined the faculty of the Calgary unit of the University of Alberta as assistant professor in charge of the health education program of the student teachers. She has also been appointed as adviser to the schools of nursing in Alberta. These two important pieces of work will bring Miss Cogswell into close contact with the large numbers of young women who are preparing to make their contributions in these active professions.

A native daughter of the province in which she works, Miss Cogswell secured her B.A. from the University of Alberta and turned first to high school teaching. When she decided to become a nurse, she chose the Royal Victoria Hospital, Montreal, as her school of nursing. She worked as a head nurse there for two years following graduation. Though she qualified in public health nursing at the McGill School for Graduate

Nurses, a brief experience in the rural field convinced Miss Cogswell that she was happier in hospital work. She spent four years as head nurse on a private floor at the Royal Alexandra Hospital, Edmonton, then became head of the teaching department there.

New development were stirring in professional nursing and when the Nurse Placement Bureau was organized by the Alberta Association of Registered Nurses, Miss Cogswell was chosen as its director. In 1948 this Bureau was merged with the National Employment Service. Miss Cogswell continued to direct it under this auspices until she resigned to become assistant superintendent of nurses at the newly opened Aberhart Memorial Sanatorium in Edmonton in January, 1952.

Possessing the happy faculty of being able to understand the other person's point of view and with a keen mind to assess difficulties fairly and honestly, Miss Cogswell will continue to strengthen the work of the nursing profession in Alberta. As an able liaison with the teaching profession, her new work will promote greater mutual understanding.

MARGARET O. COGSWELL

Jean Campbell Marsh is now a lecturer in the School of Nursing, McMaster University, Hamilton. A graduate in 1946 of the Toronto General Hospital, Miss Marsh wisely decided to seek experience away from the heavily populated areas. She joined the staff of the Red Cross Outpost Hospitals and worked in northern Ontario before turning to the University of Toronto for post-graduate work. She graduated this year with the degree of Bachelor of Arts and a diploma in nursing education. For her last year of study she was awarded a Kellogg Foundation fellowship under the sponsorship of the McMaster School of Nursing. During this time Miss Marsh studied the programs of the schools of nursing at the University of Pittsburgh and the University of Syracuse.

JEAN MARSH

Flora M. Lamont is now the director of the Shriners' Hospital for Crippled Children in Montreal where, for the past 14 years, she has been the able assistant. A graduate of the Western Hospital, Toronto, Miss Lamont engaged briefly in private nursing before joining the staff of T.W.H. as a head nurse, first in the surgical then in the obstetrical department. She joined the staff at Shriners' Hospital following the completion of the course in teaching and supervision at McGill School for Graduate Nurses. Off duty, Miss Lamont enjoys music, a game of golf or a friendly game of bridge.

Dorothy (Fox) Easter has been appointed superintendent of nurses of the Norfolk General Hospital, Simcoe, Ont. After several years in private nursing, Mrs. Easter, a graduate of the Toronto General Hospital, went to West China. After becoming proficient in the language she began

her work as superintendent of the Women's Hospital connected with the West China Union University in Chengtu. On her return to Canada she served as operating room supervisor at St. Paul's Hospital, Hearst, Ont., then went to T.G.H. as an administrative supervisor. For the past three years Mrs. Easter has been lady superintendent of Bruce County General Hospital, Walkerton, Ont.

Aini Enne Marjatta Mikkanen is one of the distinguished European nurses who has come to work in Canada. Presently on the staff of the Shriners' Hospital, Winnipeg, Mrs. Mikkanen is a graduate of the Vaasa Nursing School in Seinäjoki, Finland. Soon after her graduation in 1941, she was plunged into military nursing service in the war between Finland and Russia. She was awarded both the Distinguished Service Order Medal and the Medal of Freedom by her country. Following the close of hostilities, Mrs. Mikkanen became a supervisor in a unit providing care for the infants of tuberculous mothers.

Constance E. Brewster, who since 1934 has been director of nursing at the Hamilton (Ont.) General Hospital has retired and now resides in her home town, Brantford, Ontario. A graduate in arts from Victoria College, University of Toronto, Miss Brewster taught high school French in Regina, Sask., for several years before she entered the school of nursing of the Royal Victoria Hospital, Montreal, to begin her long and distinguished career in nursing.

Following the completion of a year's work at McGill School for Graduate Nurses, Miss Brewster went to H.G.H. as instructor. Her administrative ability was quickly recognized and she was promoted to the post of assistant superintendent of nurses. Last May the alumnae association presented a portrait of Miss Brewster, a colored photographic study done by Hubert Beckett, to the hospital as a lasting tribute to the sterling leadership of this quiet, reserved lady.

In addition to carrying the responsibility for the nursing service of a large general hospital and the education of the hundreds of student nurses who have graduated over the years, Miss Brewster has been associated in executive capacities with various active organizations — the Registered Nurses' Association of Ontario, the Ontario Hospital Association, the Victorian Order of Nurses. Her countless friends and admirers wish her many years of happiness.

It is with sincere regret that we record the resignation of **Catherine W. Perkins** from the post that she has ably filled for the past 14 months as assistant editor of *The Canadian Nurse*. Miss Perkins feels that the

CONSTANCE E. BREWSTER

Knight, Victoria

CATHERINE W. PERKINS

call to return to active participation in the public health nursing field is too strong to be denied. Wishing her well in her return to this branch of nursing in which she was formerly engaged, we shall look forward to future contributions she may be able to make to our *Journal* through articles.

Lilla Geraldine Hartwell, who for many years occupied key positions in the hospitals operated by the United Church of Canada in China, is enjoying her retirement in Toronto. Almost immediately after her graduation in 1914 from the school of nursing then operated by the General Hospital, Nanaimo, B.C., Miss Hartwell began her long career in medical missionary work. She became proficient in the dialects and prepared much material in Chinese, including a textbook, for the instruction of student nurses. Not content with her own preparation, Miss Hartwell rounded out her professional experience by taking a course in dietetics and also by qualifying for her public health nursing certificate at the University of British Columbia. For 11 years she was examination secretary for the West China division of the Nurses' Association of China. Prior to her retirement, on her return to Canada she joined the staff of the General Hospital, Bella Coola, B.C.

Despite the present-day conditions in the land where she served faithfully for so many years, Miss Hartwell feels that the work was not in vain.

In Memoriam

Helen MacMurchy, one of the first women to graduate in medicine from the University of Toronto and internationally known for her early interest in child welfare work, died at Toronto on October 8, 1953, at the age of 91.

Lending her prestige as a medical woman to the struggling infant, *The Canadian Nurse,* when our *Journal* was first established in 1905, Dr. MacMurchy was the editor from 1905 to 1911. In 1920 she was appointed chief of the Federal Division of Child Welfare. She retired from active practice in 1934.

DR. HELEN MACMURCHY

* * *

Bessie J. Allen, a graduate of the General Hospital, Saint John, N.B., died in Moncton on September 23, 1953, from injuries received when she was struck by a car. Mrs. Allen, who was 73, was a past president of the Moncton Nurses Hospital Aid. She had been engaged in active nursing until a few months ago.

* * *

Katherine Brandon, who graduated from the Winnipeg General Hospital in 1937, died of poliomyelitis in Edmonton on September 22, 1953, at the age of 41. Miss Brandon worked as a supervisor at W.G.H. following graduation until she enlisted in the nursing service of the R.C.A.F. in 1941. When she was discharged in 1946 she studied for her certificate in public health nursing at the University of British Columbia. She went to Alberta where she was nurse in charge of the Foot Hills Health Unit. Last year she joined the Department of Indian Affairs and at the time of her death was supervisor of field nurses with the Indian Health Services in Alberta.

* * *

Olivette Cadieux, who graduated from the University of Ottawa School of Nursing in 1951, died suddenly in Ottawa on Septem-

ber 29, 1953, at the age of 23. Miss Cadieux had been on the staff of the Ottawa General Hospital since graduation.

* * *

Florence Mary Casson died at the Veterans' Hospital in Victoria, B.C., on September 6, 1953. During World War I, Mrs. Casson served with the C.A.M.C. in France and Belgium.

* * *

Charlotte (Younghusband) Clayton, an early graduate of the Royal Jubilee Hospital, Victoria, B.C., died in Victoria in August, 1953, at the age of 74. Mrs. Clayton was one of the first of the nurses to go overseas during World War I.

* * *

Ethel May Dawson, who graduated with the first class from the General and Marine Hospital, Collingwood, Ont., in 1900, died on October 3, 1953, at the age of 78. For many years Miss Dawson was the public health nurse in Collingwood. In 1949, a beautiful stained glass window was unveiled in her own church in tribute to her unselfish devotion to the people of her community and in appreciation of her unlimited contribution to the welfare of the town.

* * *

Bertha Forgie, who graduated from the Royal Victoria Hospital, Montreal, in 1909, died there on July 25, 1953, after a brief illness. Engaged in private nursing most of her professional life, Miss Forgie served overseas with the C.A.M.C. during World War I.

* * *

Margaret Jessie Gidman died on July 11, 1953, at the age of 82. A district nurse in England before coming to Canada, Mrs. Gidman was an early staff member of the Victorian Order of Nurses and was the first matron of the Taber (Alta.) Hospital where she passed away.

* * *

Margery Gushue-Taylor died at Qualicum Beach, B.C., on September 2, 1953, at the age of 71. Trained in England, she had nursed for 30 years in Formosa, spending some 15 years' work with the lepers. For a time prior to her retirement in 1945, she was with the Columbia Coast Mission at Alert Bay, B.C.

* * *

Helen Kallio, who graduated from the Royal Columbian Hospital, New Westminster, B.C., in 1951, was killed in a motor accident during September, 1953. Miss Kallio was a staff member at R.C.H. at the time of her death.

* * *

Florence (Laite) Macnaughton, a graduate of The Montreal General Hospital and of the McGill School for Graduate Nurses, died at Kitchener, Ont., on August 2, 1953. For a number of years prior to her marriage Mrs. Macnaughton was nurse in charge of the Moncton (N.B.) branch of the Victorian Order of Nurses.

* * *

Kathryn McDonell, a graduate of the Ottawa General Hospital, died on September 18, 1953. She had been in failing health for several months. After completing her public health nursing course at the McGill School for Graduate Nurses, Miss McDonell joined the Victorian Order of Nurses. For 10 years she had served with the Order in Woodstock, Ont., and in Toronto. Lately she had been on the public health staff of the Township of East York.

* * *

Edith Northgraves, who graduated from the Royal Victoria Hospital, Barrie, Ont., in 1917, died in Toronto on September 25, 1953, at the age of 60.

* * *

Janet Gordon Porteous, who graduated from the Calgary General Hospital in 1943, died on September 23, 1953, following a brief illness, aged 34. After graduating, Miss Porteous enrolled for post-graduate training at the McGill School for Graduate Nurses then returned to C.G.H. as a clinical instructor, later becoming a ward supervisor. For the past few months she had been on the staff of the Community Nursing Service.

* * *

Gisèle Rheault, who graduated from St. Sacrement Hospital, Quebec City, in 1948, was drowned on August 9, 1953. She was 26 years of age. Miss Rheault was on the staff of Queen Mary Veterans' Hospital, Montreal.

* * *

Ella May Sherk, a graduate of the Brantford (Ont.) General Hospital, died in Simcoe, Ont., on September 4, 1953, following several months of illness. She was in her 78th year. For 25 years Miss Sherk had been active professionally in Woodstock, Ont. She retired in 1946.

Focus on . . .

Communicable Diseases

ANNA V. MATZ, public health consultant in communicable diseases with the New York City Department of Health, in an article in the July, 1953, issue of *Nursing World*, feels it is time to review current knowledge regarding communicable diseases, and determine whether our teaching is effective and practical. In the modern concept, says Miss Matz, communicable disease is a result of the interaction of three factors — the agent, the host, and the environment.

"As long as an equilibrium exists among the factors, health is realized. When the equilibrium is disturbed, disease results. Neither the agent alone, nor the environment alone causes disease. It results only from a disturbance in the relationship of all three."

Miss Matz cites as an example the fact that the agent of disease may be present without causing disturbance, as when diphtheria is introduced into a well immunized community. Or there might be a susceptible host with the agent lacking, as in the Faroe Islands, where no case of measles had been seen for 60 years because the community was isolated and the disease had not been introduced. When a case of measles was introduced, almost everyone on the island contracted it.

The dramatic decline in the morbidity and mortality rates from communicable disease in the past 50 years has been largely due to improved knowledge and practice along three lines: methods of attacking the agent of disease; bolstering up the defences of the host; and improving the environment so as to make it difficult for the agent to survive.

Regulations governing water supply, sewerage, garbage disposal, pasteurization of milk, control of feed, sanitary plumbing, etc., have done wonders in controlling the incidence of diseases like typhoid fever that are spread by fecal contamination.

Continued research in immunology has enabled us to immunize susceptible persons against a number of communicable diseases such as smallpox, diphtheria, whooping cough, tetanus, cholera, plague, typhus, typhoid and paratyphoid fevers, and to confer limited immunity against measles. Some progress is being made in the development of active and passive immunity against mumps and poliomyelitis. New drugs and antibiotics, specific against many agents of disease, are rapidly being produced.

With these new developments in the threefold attack on the environment, the host, and the agent of communicable disease, it is inevitable that our present methods of approach should require careful review. For instance, the need for special hospitals for communicable diseases is open to question. Can we not treat the patient with a communicable disease as a unified whole rather than as a disease entity? It should be possible to care for him in a general hospital, with modern therapy and proper safeguards.

Changes have taken place, too, in the virulence of some of the causative agents. Scarlet fever has for some years been a mild disease and its control presents a different problem than in the past.

Our attitudes and fears about communicable diseases require a change and we need to become oriented to the changing philosophy regarding medical and nursing care of these patients. It is illogical to believe that the nursing needs of such patients are different from those on medical, surgical, obstetrical, and pediatric services.

At present, there is wide variety in what is taught and the method of teaching. A certain allotment of time is made for lectures on acute communicable diseases, tuberculosis, and venereal diseases. In many cases it is completely unrelated to clinical practice, as patients who have these conditions are transferred to other units. Some students are provided with an affiliating experience at communicable disease hospitals and others never have an opportunity to either observe or care for such patients. It is necessary, then, to determine how communicable disease nursing can be integrated into the general curriculum.

Miss Matz believes it should be taught as cases occur in the different services. Tuberculosis, for instance, should be included under general medicine and pediatrics, since it occurs in both children and adults, pre-

senting different problems in each. Measles and chickenpox, which are almost exclusively children's diseases, should be a part of pediatrics; syphilis belongs in dermatology or medicine. Thus, a broader field of experience would be provided for the student in the most effective and economical way.

The biological and epidemiological concepts must of necessity be considered, and proper safeguards used, based on the communicability of a specific disease rather than on general application of routine procedures. The mechanics of control have had to change greatly in response to newer knowledge. Nursing care has been simplified by the use of antibiotics and more exact knowledge of the methods of spread of various diseases. Concurrent disinfection and proper disposal of discharges from the patient are being given more attention than the terminal disinfection of clothes, furniture, floors and walls afterwards.

Nursing care in communicable diseases is not a specialty and is the same as nursing for all other diseases. Stress should be laid on proper hygienic measures, particularly frequent hand washing and education of the patient to prevent spread, and on proper medical measures to prevent complications. The nurse should be aware of modern trends so that she can instruct the patient and the family, not only about hygienic measures, but also about immunity and other protective measures.

Undulant Fever

ALTHEA POWERS, in the August, 1953, issue of the nursing magazine *R.N.*, warns against the consumption of unpasteurized milk or milk products, as a source of undulant fever. She states that the causative organisms, the brucella, employ fifth-column tactics in their invasion of the body so that the symptoms are masked, and may lead the physician to suspect diseases such as typhoid fever, malaria, tuberculosis, or others. The onset is often insidious; it is difficult to diagnose, with the possibility of reappearance after remissions lasting six months or more.

Undulant fever, or brucellosis, may arise from direct contact with infected animals and their surroundings or from the ingestion of milk or milk products containing living brucella, says Miss Powers. The disease is commonly found among meat-packing employees, farmers,, livestock producers, and veterinarians, because animals that are apparently healthy can shed large numbers of brucella without showing any outward signs of the disease.

The brucella gain access to the body through the digestive tract, abrasions in the skin, or possibly the mucous membranes of the nose and throat. They travel to the lymphatic glands of the pharynx and mediastinum, later migrating by way of the blood stream and lymphatics to become localized in a particular tissue or organ anywhere in the body. Like the tubercle bacilli they establish a stronghold in the very cells of the tissue.

The infections may be either acute or chronic and the onset sudden or insidious. The more common symptoms are chills, fever, night sweats, generalized aches and pains, severe headaches and insomnia. The temperature may go to 104 or 105 degrees in the evening, dropping to nearly normal by morning. Weakness is almost always present, often very pronounced; nervousness and irritability are common features of the disease. Bone lesions are not infrequent though permanent joint damage rarely occurs. Miscarriages or abortions in pregnancy are no more likely to occur from brucellosis than from any other serious bacterial infection.

Miss Powers observes that "acute brucellosis may run its course in two or three weeks or it may become chronic . . . chronic brucellosis may also appear as the beginning phase of the disease." It is in the chronic phase that long periods of remittent fever alternating with afebrile periods — the classic undulating fever — are observed.

For accurate diagnosis there must be a history of exposure to the disease, objective evidence of illness, and the presence of brucella agglutinins in the blood, especially in a titer of at least 1:100. The principal needs of the patient suffering from brucellosis are, according to Miss Powers, reassurance and rest. Too often, she says, patients are given the impression that they are suffering from an illness for which there is no satisfactory treatment so they resign themselves to a lifetime of invalidism. If

mental depression and emotional instability are marked, psychotherapy may be necessary. Other treatments at present include the antibiotics and various types of brucella antigen therapy, though authorities are not in complete accord as to its value. Prophylaxis is still of primary importance. The only logical method of preventing transmission of brucellosis to man is to pasteurize all milk and milk products. But since unpasteurized milk is still available, especially in the rural areas, one should be on guard against the inadvertent consumption of raw milk or of raw milk products.

Electrolysis

ANITA M. ROSS

ABNORMAL GROWTH OF HAIR (hypertrichosis) is caused by some type of glandular disturbance, usually in the ductless glands. Those most often responsible are the ovaries, thyroid, pituitary, or adrenals. The administration of cortisone and ACTH is also thought to influence the abnormal growth.

The sebaceous glands are small organs in the deep layers of the skin. They are usually connected with hair follicles but are also found in regions devoid of hair. Each gland consists of a single duct which terminates in a cluster of small secreting pouches. The orifices of the ducts open most often into the hair follicles. They often become much enlarged from the accumulation of pent-up secretion.

Among the physical agents, x-ray, radium, and electrolysis are used to remove hair permanently. X-ray and radium are dangerous for this purpose and are used by dermatologists only for selected cases. The dose of x-ray necessary for the destruction of the hair root is applied through the entire thickness of the skin and is often followed by atrophy and telangiectasis, with its consequent disfiguring.

REMOVAL TECHNIQUES

Electrocoagulation: High frequency current has been recommended for the permanent removal of superfluous hair. It has been claimed that neither pain nor scarring results and that the hairs can be removed very quickly by this method when the current has been throttled down to minimum amperage. In our experience this is not the case. There is considerable pain and scars are likely to result.

Electrodesiccation by high frequency or short wave: Removal of superfluous hair by this method is a well established procedure but it requires an apparatus with a suitably decreased output, producing a very fine current, with a delicate control. It enables destruction of hair follicles in rapid succession in a very few seconds. The disadvantages of this method are deeper and more extensive skin destruction, with resultant scars; and it is a painful procedure.

Electrolysis: This is practically the only method of removing hair permanently, safely and with little pain. The term denotes the decomposition of a chemical compound by the ionization effect of a direct current. In medicine it is identified with controlled tissue destruction by the caustic effect of the galvanic current.

Tweezing, wax, depilatories, shaving: These methods produce only temporary results. The theory that hairs may eventually cease to grow when these methods have been used over a period of years has not been proven.

ELECTROLYSIS

Electrolysis is delicate, tedious, painstaking and time-consuming work. As well as the necessary skill, which can only be acquired with experience after adequate training and study, it is necessary to have interest, patience, sympathy, and a knowledge of dermatology, endocrinology, psychology, electrophysics, and surgical asepsis. Not

Miss Ross is in charge of the Electrolysis Department at the Royal Victoria Hospital, Montreal.

every person can acquire the requisite skill. Some have poor coordination or are physically awkward, or have faulty vision. Others are temperamentally unsuited to the work. Some persons can learn the technique admirably but are not suited to practise except under the supervision and responsibility of a doctor.

The many serious conditions resulting from improper use of electrolysis are: scarring, pitting, disfigurement. These can be avoided by careful, conscientious, skilful work. The attitude of the operator should be one of sympathy, interest, understanding, and tolerance. Encouragement is necessary and every effort should be made to help the patient develop a hopeful outlook. Women who have hypertrichosis of the face or other parts of the body may accept it philosophically or may be extremely self-conscious and suffer much mental anguish and feelings of inferiority. Not infrequently the subjects are neurotic or psychopathic.

Electrolysis is suitable for hairs that can be easily seen, regardless of the color and texture, provided the area is not too extensive. The common areas are: the face, neck, chest, upper lip. Dark hairs are easily seen but white fine hairs are difficult to trace into the follicular orifice. As a rule it is better not to interfere with short downy hair. The patient can bleach it with a solution of mild ammonia to which peroxide is added before the ammonia dries. Dioxogen cream is also satisfactory. It is not advisable to use any dye to darken the skin.

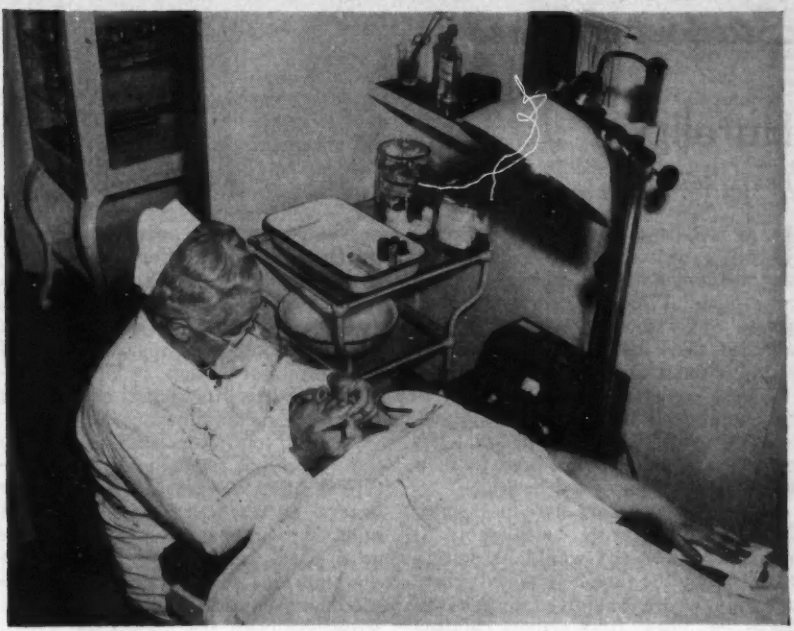
Some hair follicles are vertical, which makes the removal of those hairs, especially if they are coarse, speedy. Some follicles are curved, the direction of the curve being indicated to some extent by the angle of the visible portion of the hair. While not completely accurate, this is a useful guide. A curved follicle can, at times, be made straight by gentle traction on the skin with the hand. Even tortuous follicles can often be straightened in this manner.

A fine needle is introduced into the hair follicle by following the angle of the hair, with the galvanic current turned on slightly. This forestalls any sudden movement of the patient that might follow if the current were turned on after the needle is inserted. A small blister appears on the skin where the needle enters the hair follicle — the weaker the current, the smaller the scab, with consequent less danger of scarring. These blisters become dry and fall off within a week, leaving a slight mark the color of the surrounding skin, which usually disappears completely.

When the needle is inserted, the contact is broken after 20-30 seconds and the needle removed. Unless this is done, there is a burning sensation felt by the patient. It should be possible to gently remove the hair with tweezers when the operation has been successfully performed, and the hair shaft, root sheath, pigment sac, and root come away with the hair without effort or traction.

The number of hairs, that can be removed in one hour by a skilful operator using mild current, ranges all the way from 20 to 60 or more, depending on the type of hair and the reaction of the patient. Treatments are usually one-half to one hour in length. With mild current the treatment is unpleasant but not painful. Hairs that are less than one-fourth of an inch apart should not be removed at one sitting, nor should they be removed from skin that is inflamed or infected by pimples.

The regrowth of hairs that have been removed is estimated at from 5 to 20 per cent. With a skilful operator, the likely recurrence would be about 10 per cent. New hairs may continue to appear, sparsely or thickly, for months or several years, with or without electrolysis, because the hypertrichosis is due to a disturbance of a ductless gland. This knowledge, though discouraging to the patient, can be modified by the fact that there will likely be a limit to the number of new hairs and that after a few months of steady treatment the face will be clear of hair. For severe cases it is probable that a few treatments will have to be given yearly thereafter for a few years.



Miss Ross at work on a patient.

The majority of patients, however, grow little if any hair after treatment begins.

QUESTIONS GENERALLY ASKED

1. *Does electrolysis promote the growth of other hairs?* It has not been proven to do so but, irrespective of the large hairs having been removed, the finer hairs will continue to grow, as the cause of the hypertrichosis has not been removed.

2. *Can no scarring be guaranteed?* This is impossible, as it depends on the healing power of the patient, but 85 per cent of the cases do not scar. The pinhead scars, if any, are visible at a distance of six inches but not noticeable three feet away. The patient must be the one to decide whether she prefers the slight, hardly noticeable scars or the disfiguring hairs.

3. *How many treatments will it take?* If there are less than 50 hairs, one treatment is sufficient, but that is the maximum that can be removed in one hour. An estimate of the time needed can be made from this figure.

4. *Is the process painful?* It is not painless but the pain is bearable. Local anesthetic can be applied but it entails added expense and time. It is only used routinely in cases of extreme nervousness and to remove inward growing eyelashes from eyelids.

5. *Will the hair grow again?* Not if the hair has been completely removed.

It is important during the treatment that both patient and operator be comfortable, with the patient on a couch and operator seated at the head. The needle, held in the right hand, is inserted into the hair follicle with current turned on slightly. It is held in position until the gentle traction on the hair causes it to slide out with no resistance. *The hair should not be pulled out.*

After the treatment, hot sterile compresses are applied, then light massage to the treated area. This is followed by a special lotion and the patient is given instructions regarding care at home, as well as a sheet of written instructions to refer to.

Student Nurses

Harelip

BEATA TOMANDER

BABY NORMAN, AGED SIX MONTHS, was a well developed baby, except for one congenital deformity — he had an unilateral harelip. Since no cleft palate was associated with it, he was able to take his formula and other foods without any apparent difficulty.

There were four other children in the family, all of them normally developed and in good health. His mother and father were both in their late thirties and in good health.

The presence of harelip spoiled Norman's appearance considerably. It was realized that it would be quite a handicap by the time he reached school age. He would be forced to take all kinds of jibes from other children about his looks. This, in all probability, would cast a permanent shadow on his mental development and outlook. So far he appeared to have had all the love and care that every baby should have and to be happy and contented most of the time.

On the afternoon of April 3, Baby Norman was admitted to the hospital. The operation for the repair of the harelip was to be on April 5. He was put on formula of: canned milk 11 ounces, water 14 ounces, corn syrup 1 tablespoonful. Ounces 5 of formula was given every four hours. Small amounts of pabulum and pureed fruits were given at 10:00 a.m. and 6:00 p.m. and strained vegetables at 2:00 p.m. To supply necessary vitamins, three drops of a concentrate were added to his formula twice daily. He took his feedings eagerly and appeared quite happy in his new surroundings.

The following day and for several days after that 400,000 units of S.R. Penicillin (i.m.) was given as a preventive measure to guard against any infection during or after operation.

On April 5, the 6:00 a.m. formula was omitted. At 7:15 a.m. atropine, gr. 1/600 (hypo), was given to lessen the secretions of the gastrointestinal and respiratory tracts and thus counteract the irritating action of ether on all mucous membranes.

At 7:50 a.m. Norman was taken to the operating room, whence he returned at 9:00 a.m. He was under general anesthetic (ether). Pulse was rapid, but strong, respirations were good, skin was slightly flushed. His condition in general appeared to be good and within 15 minutes he had recovered from the anesthesia.

In the operating room precautions had been taken to keep the tension off the suture line. Tongue depressor arm restraint was used to keep his hands away from his face.

During the days that followed special care was taken to keep the suture line clean and to prevent crust formation, thus promoting healing and avoiding the formation of excessive scar tissue. Sterile normal saline and sterile cotton swabs were used for cleansing the suture line.

An hour after he had regained consciousness sterile 10% dextrose and water feedings were started to prevent dehydration. At first as little as half an ounce of fluid was given every half-hour. He retained all fluids well, so the amount was gradually increased. By evening 5 ounces of half-strength formula was given. For all feedings the curved spoon (with both sides curved up) was used. Care was taken not to touch the suture line with the spoon. Norman appeared to tolerate his feedings well so he was put on full strength formula on April 7. The vitamin drops were given as before.

On April 8, the penicillin was dis-

Miss Tomander is a senior student at the Moncton (N.B.) Hospital School of Nursing.

continued since there was no evidence of infection of the suture line and the baby's temperature had been normal for two days. The following day he was put on the same diet as he had been getting before his operation. A drink of sterile water was given after every feeding to keep the mouth clean.

All sutures were removed on April 10. The special face protection was still left in place as a precaution for two more days, should the baby put too much tension on the scar by crying. Since Norman did not seem to have the habit of thumb-sucking and seemed to keep his hands occupied without touching his face, the tongue depressor arm restraint was removed.

No post-operative complications occurred and Norman was discharged on April 16 — the 11th day after operation. The operation had been a real success and only a very fine scar on upper lip could be noticed. In his future life he will not have to go through all the mental hardships that a deformity like harelip would have caused him. Thanks to modern surgery, he will be able to lead a normal and happy life.

Book Reviews

Mental Disorders — Diagnostic and Statistical Manual, prepared by The Committee on Nomenclature and Statistics of the American Psychiatric Association. 130 pages. American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Ave. N.W., Washington 6, D.C. 1952. Price $1.50.

Reviewed by Ruby Steele, Supervisor, Psychiatric Ward, Queen Mary Veterans' Hospital, Montreal.

This manual is a reprint from "Standard Nomenclature of Diseases and Operations" and includes only terms dealing with mental illness. The Committee on Statistics of the American Psychiatric Association had, as early as 1917, adopted a classified nomenclature of mental diseases, which was suitable for use until World War II. Through military and veteran psychiatric observations much was found to be lacking in the classification, thus considerable addition and revision became necessary to include civilian, armed forces, and veteran administration nomenclature. The American Psychiatric Association established a committee of clinical and statistical observers who, after considerable research and observation of organic and psychological behavior in illness, proposed a classification that was adopted for use in 1951.

The manual includes: the standard nomenclature, definition of terms, recording of psychiatric conditions, statistical reporting and statistical classification of mental disorder. The diagnoses are listed with code numbers which are being used by veterans' hospitals across Canada and U.S.A.

The book primarily was written by doctors for doctors but can provide nurses with knowledge and information, especially Section 2, Definition of Terms. To provide the best possible nursing care should be the aim of every nurse and, to do so, one must know more than the name of the disease. To fully understand the clinical aspects of illness, the psychological pattern should also be known.

Teaching in Schools of Nursing, by Alice M. Jackson, M.A., and Katharine F. Armstrong, S.R.N. 263 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 2nd Ed. 1952. Price $3.00.

Reviewed by Norena Mackenzie, Educational Director, School for Nurses, The Montreal General Hospital.

This book is the result of the collaboration of two British teachers — one engaged in general education and the other in nursing education. The aim of the authors is to help young teachers to understand themselves, their students, and their patients and to guide them in the manner in which they discharge their responsibilities to both.

In Part I, Miss Jackson deals with the circumstances and factors that make for — and mar — the growth and development of the person. She explains simply and clearly how these forces are revealed in the young woman who is the student, in the person who is their teacher, and in the person who is a patient. Teacher-student and nurse-patient relationships are emphasized and well illustrated with examples.

The canons of learning and teaching are

presented simply and interestingly. The difficulties attending both processes are included along with suggestions — based on psychological principles and expressed with warmth and understanding — for their solution.

The Syllabus of the General Nursing Council for England and Wales is presented by Miss Armstrong in Part II. The presentation explains how schools of nursing, while meeting the demands of the Syllabus, construct their own curricula. The devices for their administration are mainly two — the Block System and the Study Day System. Both systems are clearly explained and both are acknowledged as expedient and not in conformity with educational principles.

The attraction of the book lies in its presentation. Miss Jackson is able to eschew scientific vocabulary and say what she has to say simply and kindly. However, its usefulness in Canada is not essentially as a guide for teachers. Rather, it would be valuable as a reference book for students and in assisting recently qualified nurses to adapt to their new responsibility.

George Washington University Hospital Obstetrical Nursing Procedures. 90 pages. The George Washington University, Washington 6, D.C. 1951-53.

Reviewed by Sister Miriam, Supervisor, St. Mary's Hospital, Montreal.

This is a mimeographed manual containing procedures for obstetrical routines. Each procedure is on a separate page and the manual is divided into three sections — the mother, the infant, and the delivery room. A table of contents precedes each section. If this were accompanied by an introduction or forward the purpose of each unit would be better appreciated.

The routine of this particular hospital is very clearly given and would be an excellent guide for orientation of new nursing personnel in this hospital. Instruction of the mother by the nursing staff is stressed with considerable emphasis on her self-care. It would seem that partial rooming-in program is in effect.

This manual could be used as a model for setting up or revising a ward manual in an obstetrical department but since each hospital has its own methods and procedures it would not be suitable for direct adoption.

Problems in Solutions and Dosage, by Stella Goostray, B.S., M.Ed., R.N. 266 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1952. Price $3.00.

Reviewed by E. J. MacDonald, Instructor of Nurses, Miramichi Hospital, Newcastle, N.B.

The first part is review of arithmetic, such as adding, subtracting and simple fractions, and too much space is used for this, which any student nurse should be able to do before entering training. The problems, though good, are all worked the most complicated way and they do not show any simple method which would save time and still be accurate.

On the record, 1953 will go down in history as one of the worst disaster years of the 20th century.

Within living memory, there have been few natural catastrophes to compare in extent and destructiveness with the North Sea floods of the first days of February, when a rare combination of high tides and winds of hurricane velocity sent mountainous waves smashing over the coasts of Belgium, Great Britain, and The Netherlands, taking nearly 2,000 lives and leaving some 100,000 persons homeless.

At the same time, on the other side of Europe, inland floods caused by unseasonal thaws and heavy rains made homeless 25,000 Jugoslavs — nearly 25 per cent children — and produced near-famine conditions.

A third disaster took place in the Iranian province of Mazanderan, where an earthquake took a toll of 550 lives and left hundreds homeless. In Burma, Rangoon was afflicted by its second large-scale fire within two months, while in northern Brazil thousands of residents were forced to flee to coastal areas because of famine caused by prolonged drought. Ironically, another Latin American country a thousand miles away, Ecuador, was suffering from its heaviest rain in 30 years — downpours which washed out roads and railways and completely cut off the capital city of Quito and surrounding mountain areas from all food supplies. Then, Turkey was shaken by devastating earthquakes. The list of casualties reached nearly 600 while 22,000 houses were destroyed or damaged.

Greek communities on the Aegean islands, that were rocked continuously by earthquakes for hours and days, suffered many thousands of casualties.

All these catastrophes met with immediate attention on the part of the League of Red Cross Societies which, together with its Member organizations, undertook a relief action whenever such was asked for by the Societies of the countries stricken.

In the Good Old Days

(*The Canadian Nurse* — DECEMBER 1913)

"DURING THE TONSILLECTOMY, the nurse should be prepared to sponge the interior of the throat when required to do so; she should also have a quart jug of very cold water, iced if possible, with which to douche the face and neck. This acts reflexly, contracting the vessels and lessening the hemorrhage as well as stimulating the patient."

* * *

"A list of the pupils absent from school on account of contagious diseases is posted in the office of each school each week. The teachers are instructed not to admit to their classroom any pupil whose name appears on the list . . . The notifications sent to parents in regard to the need for treatment for defects of their children's teeth are more neglected than any of the other notices sent home."

* * *

"A survey of public health nursing in Canada would reveal work of which we would feel justly proud. A committee has been set up to report upon the advisability of forming a Public Health Nurses' Association in 1914. If public health nursing can be made a section of the C.N.A.T.N. it would avoid another association and another annual meeting . . .

"The improper use of the name 'public health nurse' has caused much confusion and misunderstanding among nurses not familiar with the different bodies doing public health work. It is a broad term that includes all nurses doing public welfare work. It is incorrect and confusing to use the name to specially designate the board of health visiting nurse."

* * *

"Exercise is the best medicine for the body. We cannot imagine how favorable to health it is for it excites the flow of spirits and facilitates the excretions from the blood."

* * *

"Ten thousand tooth brushes and 13,000 tubes of tooth paste were sold at cost to school children in Toronto, during 1912, by the Department of Medical Inspection."

* * *

"A training school for nurses was established with the £50,000 that was the outpouring of a nation's gratitude to Florence Nightingale. It was to be a home from whence all that was good and pure should emanate; from whence women should go forth, carrying with them the lamp of knowledge and power, as well as love, to lighten the dark places of the earth, even as she, their founder, had carried the lamp through the dark wards of Scutari Hospital."

Ontario

The following are staff changes in Ontario Public Health Nursing Service:

Appointments — *Grace Leavey* (St. Joseph's Hosp., Hamilton, and B.S. in nursing, Seton Hall University, West Orange, N.J.) as supervisor, Halton Co. health unit;

Mary (*Buchanan*) *Brackenboro,* formerly with Peel Co. health unit, to North York Township board of health; *Dorothy Deeble* and *Heather Matthew,* formerly with Peel Co. health unit, to Muskoka district health unit; *Emilienne Dion* (Hôp. de L'Enfant Jésus, Québec, and University of Montreal) to Prescott and Russell health unit; *Jean* (*Fortner*) *Glover* (Victoria Hosp., London, and University of Western Ontario cert. course) to York Township board of health.

Ruth Head (Hamilton Gen. Hosp. and University of Toronto gen. course) to Haldimand Co. school health service; *Eileen* (*Gall*) *Holmes,* formerly with Muskoka district health unit, to North Bay board of health; *Patricia Lees* (St. Joseph's Hosp., Hamilton, and U. of T. gen. course) to Timiskaming health unit; *Olive McKeachnie,* formerly with Kenora-Keewatin-Dryden area health unit, to Brant Co. health unit; *Giselle Meloche* and *Hilda Willis,* formerly with Lennox and Addington health unit, to Ottawa board of health; *Dorothy Nakamachi* (St. Paul's Hosp., Vancouver, and U. of T. gen. course) to St. Catharines-Lincoln health unit; *Miriam* (*Snyder*) *Sokvitne* (St. Mary's Hosp., Kitchener, and U. of T. gen. course) to

Kitchener board of health; *Grace Walters,* formerly with Stormont, Dundas and Glengarry health unit, to York Co. health unit; *Dorothy (Campbell) Wilson* (Ottawa Civic Hosp., and McGill University public health nursing course) to Middlesex Co. school health service; *Elizabeth Wilson,* formerly with Northumberland and Durham health unit, to Scarborough board of health.

Resignations — *Thelma (Smith) Gordon* from Timiskaming health unit; *Eva Hubman* from Fort William and district.

Victorian Order of Nurses

Appointments — As nurse-in-charge — Digby, N.S.: *Edith Hill* (University of Western Ontario). St. Thomas: *Mary H. Law* (U.W.O.). Truro: *Nora Stratford* (McGill University). To staff — Brantford: *Alma J. MacLeod* (Queen's University). Burnaby, B.C.: *Pauline Paterson* (University of British Columbia). Chatham, Ont.: *Dorothy E. Prentice* (University of Toronto). Corner Brook, Nfld.: *Joan E. Coughlan* (Queen's U.). Cornwall: *M. Ardonna Johnston* (U.W.O.). Medicine Hat: *Margaret E. Bath* (University of Alberta). Moncton: *Raymonde Picard* (University of Montreal). Niagara Falls, Ont.: *Ruth (Stuart) Ferguson* (Queen's U.). and *Olga J. Roman* (U. of T.). North Vancouver: *Carolyn M. Ree* (U.B.C.). Ottawa: *Paquerette Boily* (U. of M.), *Jacqueline Girard* (U. of M.), and *Johanne Theill* (McGill U.). Owen Sound: *June Fredin* (U.W.O.). Preston, Ont.: *Dorothy I. Brown* (U.W.O.). Ste. Anne de Bellevue, Que.: *Janine Bouffard* (U. of M.). Sarnia: *Hilda M. Brown* (U.W.O.). Sudbury: *Marie Y. Hurtubise* (University of Ottawa). Toronto: *Marion A. English, Marilynne J. Fraser, Audris (Spicer) Gleason,* and *Margaret A. Moreland* (all University of Toronto). Truro: *Mary E. Blair* (Queen's U.). York Township, Ont.: *Ille Toolse* (U. of T.).

Reappointments — As nurse-in-charge — Brampton: *Doreen E. Parker.* Brockville: *Catharine Miller.* Chatham, N.B.: *Elizabeth E. MacKenzie.* Cobalt, Ont.: *Joy A. Chesser.* Elphinstone, B.C.: *Elizabeth Godwin.* Kirkland Lake: *Margaret C. Jones.* Leamington, Ont.: *Alice L. McDonald.* Newcastle, N.B.: *Ruth A. Garnham.* Rouyn-Noranda, Que.: *Marie B. Maille.*

Smiths Falls, Ont.: *Sheila Rymer.* Whitby, Ont.: *Marjorie C. Smith.* Yarmouth: *Jean Thornber.* To staff — Lachine, Que.: *Thérèse Gaudette.* Surrey, B.C.: *Alsie L. Batten.* Toronto: *Irene E. Boake* and *Gladys I. Simpson.* Victoria: *Marion E. Brown.*

News Notes

ALBERTA

HANNA

Ten members were present at a recent meeting of District 5 held in the nurses' residence. Miss Greene became president by acclamation.

VULCAN

Dr. Tompkins, guest speaker at a meeting of Vulcan Chapter, held recently in the nurses' home, spoke on "The Medical Aspects of Atomic Warfare." Mrs. Manning reported on the garden party held at her home in July.

BRITISH COLUMBIA

BURNS LAKE

Twenty-eight members attended the second annual meeting of Central Interior District held in September. The nurses represented the areas of Prince George, Smithers, Burns Lake, and Prince Rupert. C. Preston welcomed the visitors and announced that arrangements for the formation of a chapter in Burns Lake had been completed. Highlight of the meeting was a panel discussion on the need for a home for the aged in the area. Views were presented from the hospital and public health angle and statistics supplied by the Social Welfare Service and the Prince George City Council were given. Members agreed that such a home was vitally important and it was decided that the chapters should discuss the matter more fully.

Following the meeting, the members were taken on a tour of the Home for Senior Citizens in Burns Lake, which accommodates ten patients.

The following officers were elected: President, Mrs. C. Woodgate; vice-president, C. Preston; secretary, Mrs. W. Warner; treasurer, Mrs. N. Layton.

COMOX

A regular meeting of Vancouver Island District was held here with over 40 members from island points present. Mrs. A. Quayle of Ladysmith Chapter has been elected president, succeeding Mrs. M. Neville. An addition to the by-laws regarding financial reimbursement to the island executive for unusual expenses incurred in attending meeting was passed. Mrs. N. Bennett of Nanai-

mo was appointed *Canadian Nurse* representative. It was reported that — Duncan Chapter held a bursary tea; Nanaimo Chapter also held a similar tea, featuring a raffle, candy stall, and home-cooking; Chemainus Chapter has disbanded for the present due to a lack of interest.

Mr. Haig-Brown was guest speaker and spoke on "The Country Magistrate." He is a noted author, naturalist, and magistrate of Campbell River.

Nelson

At recent meetings of Nelson Chapter, the highlight of events was the talk by Flora MacLean, president, on her trip to attend the I.C.N. Congress in Brazil. A presentation was made to R. (Hornett) Wilson, past active member, now residing in Trail.

Misses Lee and Latimer chauffeured eight members on the 150-mile trip to New Denver to attend the semi-annual district meeting held in September.

Members and hospital staff addressed 3,300 letters to taxpayers, urging their support of a new hospital. Aided by chapter and hospital staff, 1,106 persons were given free chest x-ray at the West Kootenay Fall Fair.

Prince George

At the first fall meeting of the local chapter, the report on the provincial convention, prepared by G. Gowans, was read by E. Braund. Miss Gowans has left on a year's leave of absence to study at McGill University and, prior to her departure, she was presented with a travelling clock.

It was suggested that a civil defence course be held for auxiliary nursing personnel this winter. This would be similar to the courses on the nursing aspects of A.B.C. warfare given to the nurses during the past two years. It was reported that around $200 was cleared at the June dance.

At a later meeting the members viewed films on the work done by ICEF and WHO among the world's undernourished children. They also enjoyed movies on curling and the Royal Military College of Canada. As D. Munro is leaving the Chapter, Mrs. W. Warner volunteered to serve as treasurer.

MANITOBA

Brandon

The Association of Graduate Nurses met at the General Hospital recently. The president, Mrs. E. Hannah, was in the chair.

The following are the new executive for the year: President, Mrs. E. Hannah; vice-presidents, J. Higgens, Mrs. J. Brereton; secretary, Mrs. T. Moir; treasurer, J. Harding. The following are also serving in various capacities: S. Strang, A. Bennett, I. Lamont, P. Beecher; Mmes G. Hannah, R. Darrach, M. McNee, M. Skene, D. Speakman, A. Hallett, R. Catley.

Mrs. E. Hannah and E. Cranna were delegates to the M.A.R.N. convention held in Winnipeg. It was announced that R.

Lane, this year's scholarship winner, is attending the University of Manitoba.

Meetings are held on the first Tuesday of each month.

VIRDEN

Janet Campbell, acting matron of Virden Hospital, has joined the staff of Virden Medical Clinic. On behalf of the members of the board, staff and friends, who gathered to say *Au revoir,* Mr. Brayfield wished her success in the future and Mrs. H. Beerman presented her with a set of travelling bags. At a weiner roast held by staff members in her honor, Miss Campbell was presented with a camera.

NEW BRUNSWICK

FREDERICTON

At the first fall meeting of the Fredericton Chapter held in Victoria Public Hospital, a motion of regret in the deaths of Misses F. Breau and G. Pond was entered in the minutes. D. Loane, the new V.O.N. nurse, was welcomed by Mrs. M. M. Scott, the president. P. O'Donnell and M. Dick reported on the N.B.A.R.N. annual meeting which they attended as student-guests. In the absence of the guest speaker, Lois Smith, her paper, "A Review of the N.B.A.R.N. Annual Meeting," was presented by K. MacLaggan. A social evening and refreshments, served by M. Bird and Mmes M. Menzies and E. Rankine, followed.

MONCTON

Mrs. N. Smith was in the chair at a meeting of Moncton Chapter when she gave an informative account of the N.B.A.R.N. annual meeting held in Fredericton. A nominating committee, consisting of Mrs. Moore, Misses Fowler and S. McLeod, was named to bring in a slate of officers for the coming year. At the conclusion of business, refreshments were served by Mrs. Galbraith of the Practical Nurses School, locale of the meeting, and the nurses of the Tuberculosis Hospital.

SAINT JOHN

St. Joseph's Hospital

Sr. Loretto, a graduate of Holy Family Hospital, Prince Albert, Sask., has been appointed to the hospital staff. At the convocation of St. Louis University in February, Sr. Loretto will receive her master of science degree in hospital administration. Sr. Theresa Carmel has resumed her position as head nurse in the pediatrics department after a year's study in clinical supervision in pediatrics at the University of Toronto School of Nursing and Hospital for Sick Children, Toronto.

ST. STEPHEN

At the annual meeting of the local chapter, the following officers were elected: President, M. McMullen; vice-presidents,

Mmes D. Higgins, M. Gibson; secretary, M. McFarlane; treasurer, Mrs. J. Anderson.

H. Bartsch and C. Boyd attended the N.B.A.R.N. annual meeting held in Fredericton. Mrs. Anderson, Misses Mark and A. Spinney were present at the banquet.

NEWFOUNDLAND

ST. JOHN'S

St. Clare's Mercy Hospital

Nineteen graduates took part in the commencement exercises of the School of Nursing held in November. The Most Rev. P. J. Skinner, Archbishop of St. John's, presided.

NOVA SCOTIA

ANTIGONISH

St. Martha's Hospital recently sponsored a nursing institute under the leadership of Sr. Claire Marie, director of nursing education. E. M. Howard, assistant professor of nursing, University of Toronto, was guest speaker. Other participants in the program were: Rev. M. A. MacLellan, principal, Xavier Junior College, Sydney, and Rhoda MacDonald, school of nursing advisor in Nova Scotia. Emphasis was on the work of the head nurse as administrator and teacher. Special social events were arranged for the entertainment of the members.

HALIFAX

Children's Hospital

Mrs. H. Stacey, superintendent of nurses at the Children's Hospital since 1947, will be succeeded by Mrs. G. Shane, present assistant superintendent, as acting superintendent. Winnifred Chute, recently returned from Christian Medical College, Vellore, India, will be science instructor.

School of Nursing

Dalhousie University

The School of Nursing sponsored a two-week work conference on "Ward Management and Clinical Teaching" in November. The period was spent in discussion and study of problems of personnel, education of student nurses, use of nurses' aides (assistants), and simple teaching methods.

Phyllis Lyttle is superintendent of public health nurses, N.S. Dept. of Health, following post-graduate study in administration at University of Toronto; June MacGillivray is instructor of nurses at New Waterford General Hospital; Walter MacDonald, clinical instructor at Nova Scotia Sanatorium, Kentville; and Jean Clack, junior matron, School for Nursing Assistants, Camp Hill Hospital, Halifax.

Victoria General Hospital

Maisie Miller, superintendent of nurses, Victoria General Hospital, has returned after a year's study at the University of Toronto, and Frances MacDonald, assistant

superintendent of nurses, has been named educational director.

ONTARIO

District 2

Tillsonburg

The opening meeting of the season of the registered nurses was held in the nurses' lounge of the hospital. The president, Mrs. F. Rubie, was in the chair and Mrs. A. Woolley gave an interesting talk on her trip through the west. Refreshments were served by Mmes B. McDonald and Rubie, and Miss M. Sinclair.

District 4

St. Catharines

The members of Niagara Chapter met recently at Niagara Peninsula Sanatorium to hear an interesting paper on "New Trends in the Care and Treatment of Tuberculosis" by Dr. E. T. Peer, who is on the medical staff of the sanatorium. It was a pleasure to welcome visitors from England, Saskatchewan, and Ontario. A social hour followed the lecture, the hostess being M. McCort, superintendent of nurses.

District 5

Whitby

About 150 nurses from Toronto attended the fall general meeting of District 5 held at the Ontario Hospital. They were conducted through the hospital and demonstrations of various treatments were given. Dr. C. N. Richards, chief surgeon, spoke at the dinner on "Recent Advances in the Treatment of Psychiatric Patients."

Toronto

Women's College Hospital

Misses Groocock, Butt, and Bowlby are taking public health or hospital administration and Miss Kingsford, clinical supervision in psychiatry, at University of Toronto School of Nursing. D. Kimball is obstetrical supervisor at W. C. H. on the evening shift while V. Gardhouse is doing floor duty. P. Murray is working in a doctor's office in California. G. (Andrews) Achilles is nursing in an infirmary in Mosher, Ont., a lumber community. Mrs. (Thomas) Foster is in a dispensary in Northern Rhodesia. J. Purvis has joined the nursing staff of the R.C.A.F. E. McKenzie is on duty at the Cobourg General Hospital.

Mrs. (Innes) McMillan is nursing with the Philco Corp. of Canada Ltd. E. McGarrigle is on the staff of the new Mt. Sinai Hospital, Toronto. Misses Bryant, Lockhart, and Prosser are with the Toronto branch of the V.O.N. C. Mackid is taking nursing education at Toronto University.

The address of the treasurer, Mrs. Stan Hall, is *86 Hounslow Ave., Willowdale.*

District 6

Belleville General Hospital

Twenty-two members attended the first fall meeting of the alumnae association of the School of Nursing. The slate of officers elected is as follows: Honorary presidents, M. L. Peart, Mrs. G. Rutherford; president, Mrs. D. Howie; vice-presidents, Mmes D. Taylor, B. McCreary, J. Holway; secretary, Mrs. I. Burns; treasurer, Mrs. E. Portt.

Tribute was paid to Mrs. Rutherford as one of the first organizers of the association. After the business meeting, Mrs. E. Dowsett and her committee served refreshments.

District 8

Ottawa

An Ottawa area chapter of District 8 was established at a rally of some 200 nurses held recently. Nurses attended from the Cornwall, Pembroke, and Ottawa areas. Edith Fenton, R.N.A.O. public relations secretary, was guest speaker.

District 12

Kapuskasing

Over 60 Cochrane and Timiskaming nurses attended a recent district rally and banquet at Kapuskasing Inn. The arrangements were supervised by S. Coutts. K. King, district chairman of Kirkland Lake, presided at the dinner. Edith Fenton, R.N.A.O. public relations secretary, was guest speaker and the theme of her address was "Wide Horizons," defining the scope and significance of the nursing profession.

Seated at the head table were: Misses Rich, Allen, King, Mullen, Mmes MacKay and Robson, with the guests, Mr. and Mrs. G. Minard, and Mr. T. H. Rosborough.

PRINCE EDWARD ISLAND

Summerside

N. Craig presided at the first meeting of the season held by Prince County Chapter, 25 nurses being present. Mrs. J. Cameron was elected secretary-treasurer and M. Jardine, representative to *The Canadian Nurse,* replacing B. Foster and B. Silliphant who have left the province. After a brief business session, E. Inman introduced the guest speaker, Dr. A. A. MacVicar. His topic was "Psychiatry" and he stressed the need for more nurses to enter this field. Many interesting cases were outlined.

QUEBEC

Montreal General Hospital

At a recent meeting of the alumnae association, Dr. A. T. Bazin was guest speaker. His topic, "Our Heritage," was thoroughly enjoyed. Following the meeting, a reception was held in honor of Isobel Black, newly appointed director of nursing.

The Women's Auxiliary has generously presented a television set to the nurses' residence.

Royal Victoria Hospital

Dr. Ray Lawson was guest speaker at a meeting of the alumnae association when he spoke on his trip to the Arctic, illustrating his talk with colored films and slides. The senior students were the special guests for the evening.

W. McLeod is director of nursing, Alexandra Hospital, Montreal. M. Dauphin is with WHO in Pakistan. P. Butterill is on the staff of Westminster Hospital, London, Ont. M. A. Markham and E. Hebb are serving with the R.C.N. at *H.M.C.S. Stadacona*, Halifax. R. Deachman is taking the science course in nursing, Queen's University. P. (McCullough) Roix was a recent visitor from New York.

SASKATCHEWAN

Foam Lake

Marjorie Wight, matron of the Union Hospital, was honored by the hospital staff and friends prior to moving to Ontario. J. Stephen, hospital secretary, presented her with a matched set of luggage on behalf of those present.

Saskatoon

A regular meeting of Saskatoon Chapter was held in October at the nurses' residence of St. Paul's Hospital in the form of a "new membership" tea. A. Hazen and N. Humphries did the honors at the tea table.

City Hospital

R. Miller was convener for the successful tea and bazaar held at the nurses' residence in October. Receiving guests were: Mrs. H. A. Armstrong, R. Nemanishen, J. Brown. Those pouring tea included: E. Pearston, Mmes G. Brown, E. R. Peterson, R. W. Cram, W. S. Holmes, S. Landa.

The student nurses of the 1954 "A" class sponsored an informal skirt and sweater dance in October.

New members on the staff include: L. Bilodeau, L. Brown, O. Brown, L. Carrick, M. MacKinnon, G. McKenzie, Y. Quaale; Mmes E. (Pedersen) Bonli, E. Boulton, R. Dickey, H. (Rustemeyer) Lyons, K. (McCririck) Reynolds, D. (Reid) Wilson.

Tisdale

Sr. Superior Margaret Maigan, formerly of St. Louisville Hospital, Bonnyville, Alta., has replaced Sr. Superior Anna Keohane at Ste. Thérèse Hospital. The latter is now administrator of St. Mary's Hospital, Trochu, Alta.

Positions Vacant

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Supt. for 125-bed hospital with small Training School. Apply Sec., Board of Trustees, Prince County Hospital, Summerside, P.E.I.

Educational Director for School of Nursing. 200 students enrolled. 700-bed hospital. Apply Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

Instructor of Nurses urgently required. Excellent salary & personnel policies. 65 students. Apply Miss B. A. Beattie, Director of Nurses, Public General Hospital, Chatham, Ont.

Instructor of Nurses to initiate affiliation course in Tuberculosis Nursing. Apply Director of Nursing, Essex County Sanatorium, Windsor, Ont.

Instructor of Nurses for T.B. & Infectious Diseases to student affiliating nurses. Must be R.N. with university certificate in Teaching & Supervision. Apply, stating age, experience & salary expected, Director of Public Health & Welfare, City Hall, Halifax, N.S.

Clinical Instructor (Medical-Surgical). 155-bed General Hospital. 75-bed addition in near future. Salary: $260 per mo. with complete maintenance. Good personnel policies. 44-hr. wk. Apply Director of Nurses, Chesapeake & Ohio Hospital, Clifton Forge, Virginia.

Asst. to Supervisor for large, active Central Supply Dept. Apply Director of Nursing, Hospital for Sick Children, 555 University Ave., Toronto 2, Ont.

Operating Room Nurse, General Duty Nurses & Certified Nursing Assts. for 107-bed modern hospital. Starting salary for nurses: $175 per mo. plus meals & laundry. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ontario refunded after 6 mos. service. 44-hr. wk., 8 statutory holidays, 21 days holiday with pay, cumulative sick time. Medical & hospital plan subsidized. Room accommodation available in residence. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Industrial Nurse for the British Columbia Dept. of Health & Welfare. Salary: $250 per mo., rising to $303 per mo. Duties: Under direction, to plan & operate an industrial nursing service for a large group of government employees, including period duties in connection with morbidity studies & as consultant to private industrial nursing services. Qualifications: Diploma or Degree in Industrial Nursing or Public Health Nursing. Experience: A minimum of 4 yrs. experience in Industrial or Public Health field or related experience. Apply B.C. Civil Service Commission, Weiler Bldg., Victoria, B.C.

Registered General Duty Nurses. 60-bed hospital. 44-hr. wk. 21 days annual holiday. 8 statutory holidays. 2 wks. sick leave. Apply Supt., Public Hospital, Smiths Falls, Ont.

Registered General Duty Nurses (2). 50-bed active General Hospital, 100 miles northwest of Toronto. Salary: $155 per mo. plus full maintenance. Blue Cross Hospital Plan after 3 mos. service. 18 days sick leave per yr. after 6 mos. 3 wks. vacation after 1 yr. Apply Supt., Memorial Hospital, Listowel, Ont.

Graduate General Duty Nurses. New 25-bed hospital in B.C. Peace River District. Duties to commence approximately Dec. 15. Apply, giving experience, references & qualifications, Sec., Community Hospital Society, Pouce Coupe, B.C.

General Duty Registered Nurses (2) for 30-bed hospital in northwestern Ontario, the heart of a tourists' paradise. Separate nurses' residence, fully modern. Salary: $160 per mo. plus full maintenance. Salaries subject to annual increase. 30 days vacation after 1 yr. service. Successful applicants reimbursed rail fare after 1 yr. Apply, stating age & when available, Supt., District General Hospital, Dryden, Ont.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada,
193 Sparks Street, Ottawa 4, Ont.

WANTED

CLINICAL INSTRUCTOR FOR PEDIATRICS

for

War Memorial Children's Hospital

Capacity: 140-150 beds.

Post-graduate course preferred.

Good salary and Personnel Policies.

Apply:

Director of Nursing, Victoria Hospital, London, Ontario.

Laboratory Technician. 67-bed hospital. Salary open. Apply Supt., General Hospital, Portage la Prairie, Man.

Nurses (1 or 2). 24-bed hospital. Separate modern nurses' home. Salary: $180 per mo. plus full maintenance. Usual increases after 6 mos. Holidays, sick leave. Apply Matron, Union Hospital, Vanguard, Sask.

If you are coming to Britain to nurse, you will be welcome at 324-bed Sully Hospital near Penarth, Glamorganshire, South Wales, a modern hospital on the sea. Experience available in Medical & Surgical Nursing of all Chest Diseases in adults & children. Post-graduate course for British Tuberculosis Ass'n Certificate & instruction by medical staff & tutor. Comfortable, modern Nurses' Home with recreational facilities. For further information write H. M. Foreman, M.B.E., M.B., Physician Supt.

If you are coming to Britain to nurse, you will be welcome at 240-bed Glan Ely Hospital (Pulmonary & Non-Pulmonary), Fairwater, Cardiff, South Wales. **Staff Nurses** (S.R.N.) — excellent experience available in bone & joint surgery & thoracic surgery. British Tuberculosis Ass'n Certificate may be obtained after 12 mos. service. **Student Nurses** for B.T.A. Cert. **Pupil Asst. Nurses** for Training School inaugurated with two local hospitals. All posts resident or non-resident. For further particulars write to Matron.

Nurse Supt. for new 56-bed General Hospital. Separate residence with suite. 1 mo. holiday after 1 yr. plus statutory holidays. Salary open. Apply, giving qualifications & experience with references, Miss L. Pockett, Acting Supt., General Hospital, Morden, Manitoba.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Nursing Arts Instructor by Dec. for 135-bed hospital — 70 student nurses. For further information apply Director of Nursing, Holy Family Hospital, Prince Albert, Sask.

Clinical Supervisor (qualified) for Jeffery Hale's Hospital, Quebec City, Que. For details apply Director of Nurses.

Laboratory Technician (1), Registered Nurses (5) — one with O.R. experience. Also **Grace Maternity Graduates.** Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Operating Room Nurses & Staff Nurses for 170-bed approved hospital with intern staff; half-hour from New York City. Good personnel policies. 40-hr. wk. Beginning salary for operating room nurses: $250. Social Security & Hospital Insurance. Maintenance available at minimum cost. Apply Director of Nursing, General Hospital, Yonkers 2, New York.

Public Health Nurse III for schools, homes or clinics. Must be graduate of an accredited School of Nursing & have successfully completed at least 1-yr. approved course in Public Health Nursing. Bachelor's Degree desirable but not required. 40-hr. wk. Salary: $3,783-4,498. Apply Flint Civil Service Commission, City Hall, Flint, Mich.

Public Health Nurse (qualified) for Peel County Health Unit. Interesting generalized program in rural-urban area near Toronto. Salary schedule: $2,700-3,200. For full details apply Dr. D. G. H. MacDonald, M.O.H., Court House, Brampton, Ont.

Head Nurse for Nursery in new Obstetrical Dept. Nursery supplied with Armstrong incubators, oxygen & suction, mobile cubicle units. Salary commensurate with qualifications & experience. Also **General Duty Nurses** for same unit. 3 rotating shifts. 44-hr. wk. 8 statutory holidays. Salary: $195 per mo. with differential for post-graduate study. Apply Director of Nursing, McKellar General Hospital, Fort William, Ont.

Registered Nurses for hospital, 15 miles from Banff. Gross salary: $200 per mo. less $20 maintenance. 40-hr. wk. Cumulative sick leave. 1 mo. holiday after 1 yr. service. Excellent recreational facilities. Apply Matron, Canmore Hospital, Canmore, Alta.

WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO

Head Nurse **required for OBSTETRICAL WARD**

Apply, stating qualifications, to:

DIRECTOR OF NURSES, GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

Registered Nurses for General Duty for new 300-bed General Hospital in downtown Toronto. For information re personnel policies & salaries, apply Personnel Director, New Mount Sinai Hospital, 550 University Ave., Toronto 2, Ont.

Registered General Duty Nurses immediately for active 35-bed hospital. Comfortable living accommodation. Salary: $200 with maintenance. 3 wks. vacation after 1 yr. Apply Administrator, Lord Dufferin Hospital, Orangeville, Ont.

Registered Nurses for General Duty in 600-bed hospital for Tuberculosis. Initial gross salary: $185; additional salary for operating room, surgical floor & night duty. Board, room, laundry available — $33 per mo. For further information apply Director of Nurses, Beck Memorial Sanatorium, London, Ont.

Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $285; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Staff Nurses for mixed services on private & semi-private wards in 378-bed hospital. Residence accommodation if desired. Apply Director of Nursing, General Hospital, Brantford, Ont.

General Duty, Operating Room & Maternity Nurses. Salary: $182.50 for recent graduates. 1 meal, laundry. 8-hr. day, 44-hr. wk. — straight shift. $15 differential evenings — $10 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

General Duty Nurses for 200-bed General Hospital in B.C. Interior. Starting salary: $225. Annual increments. Credit for past experience. 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 650-bed Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market, Stockton, California.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $240-270. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

HAMILTON GENERAL HOSPITAL

The Hamilton General Hospital School of Nursing invites immediate applications for:

(a) ***Supervisors and Clinical Instructors:***
(i) Medicine. (ii) Surgery. (iii) Paediatrics.

(b) ***Obstetrical Dept.*** — Staff & Graduate Floor Duty.

(c) ***Graduate Floor Duty Nurses.***

• General Hospital • 900 beds • 300 students • Opportunities for advancement

For further information write:

Director of Nursing, General Hospital, Hamilton, Ontario

Staff Nurse for Kent County Board of Health Unit. Applications will be received by the undersigned for this position. Applicants to have qualifications as laid down by Dept. of Public Health, Ont. W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ont.

General Duty Nurses & Operating Room Supervisor (salary for latter open) for attractive 60-bed hospital in Southern Ontario town. Basic salary: $200 with increments each 6 mos. to $15. Evenings & night shifts receive a bonus of $15. Benefits of free laundry, cumulative sick time, 3 wks. vacation, 7 statutory holidays. Apply Director of Nurses, Alexandra Hospital, Ingersoll, Ont.

Night Supervisor for 200-bed hospital. Apply Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ont.

Registered Nurses (2) for General Duty for 18-bed hospital in beautiful Windermere Valley, B.C. Separate nurses' home, fully modern. Salary: $210 per mo. less $40 full maintenance. Salary subject to semi-annual increases. 28 days vacation after 1 yr. service; statutory holidays & 18 days sick leave (cumulative). 8-hr. alternating shifts, 44-hr. wk. Good swimming, fishing & hiking; near Radium Hot Springs, new modern theatre. Apply, stating age, experience, references & when available, Mrs. D. Cookson, Matron, Lady Bruce Memorial Hospital, Invermere, B.C.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Floor Duty Nurses for Mount Hamilton Hospital (Maternity), Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $100. For other perquisites & further information apply Supt.

Nurse (1) with O.R. experience — salary: $230 per mo. & **General Duty Nurses** for 110-bed hospital. Starting salary: $220 per mo. for B.C. Reg. with annual increase up to $25; less $52.50 for board, room, laundry. 18 days cumulative sick time annually. 28 days vacation after 1 yr. 10 statutory holidays. Excellent golf, swimming, skiing & other recreational facilities. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia.

POSITION WANTED

Registered Nurse (highest provincial standing), university certificate in teaching, U.S. university course in clinical instruction, 6 yrs. experience in teaching. Desires position from Feb. or March — parents' classes, public health, teaching post-graduate or basic students, obstetrics specialty. Apply c/o Box F, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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ONTARIO

Registered Nurses' Association of Ontario

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec Incorporated February 14, 1920.

Pres., Mlle Eve M. Merleau, 3201 ave Forest Hill, Montréal; Vice-Pres. (*Eng.*), Miss H. Lamont, Sr. M. Felicitas; (*Fr.*), Sr. Marie-Paul, Mlle Mailloux; Hon. Sec., Sr. J. Forest; Hon. Treas., Miss E. Geiger; *Councillors,* Mlles C. Julien (*Dist. 1*), C. Samson (*2*), R. Aubin (*3*), F. St-Pierre (*5*), L. Couet (*10*). The above constitute the *Executive Council* and are *Members of the Committee of Management,* together with: Mlles I. Fredette, M.-A. Trudel, F. Verret, G. Lamarre, G. Badeaux, G. Côté, M. Olivier, Misses M. Ferguson, K. Brady, Mme M. Boisvert, Srs. Ste-Louise de Marillac, Ste-Sophie Barat. *Advisory Committee,* Misses R. Chittick, C. Bernard, E. Flanagan, C. V. Barrett, M. Gormley, Mrs. J. Green, Mlles J. Gagnon, S. Pilon, A. Martineau, B. Chalifour, Srs. Valérie de la Sagesse, St-Ferdinand. *Committee Chairmen: Institutional Nursing* (*Eng.*), Miss R. Francis, Western Division, Gen. Hosp., Mtl. 25; (*Fr.*), Sr. Ste-Louise de Marillac, Hôtel-Dieu, Québec; *Public Health* (*Eng.*), Miss P. Forbes, Children's Service Centre, 1869 Dorchester St. W., Mtl. 25; (*Fr.*), Mlle J. Lacasse, Montreal Health Dept., 671 Ogilvy St., Mtl. 15; *Private Nursing* (*Eng.*), Miss M. Gormley, 4216 Dorchester St. W., Apt. 4, Mtl. 6; (*Fr.*), Mlle B. Chalifour, 1163 rue Ploermel, Québec. *Chairman, Board of Examiners:* (*Eng.*), Miss A. Haggart, Royal Victoria Hospital, Mtl. 2; (*Fr.*), Mlle J. Trudel, Hôpital Ste-Justine, Mtl. 10; **Sec.-Registrar, Miss A. Winonah Lindsay. Visitor to French Schools of Nursing, Mlle Suzanne Giroux.** ***Association Headquarters, 1538 Sherbrooke St. W., Montreal 25.***

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Edmonton General Hospital

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University of Alberta, Edmonton

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Grace Hospital, Winnipeg

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NEW BRUNSWICK

Victoria Public Hospital, Fredericton

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Saint John General Hospital

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Victoria General Hospital, Halifax

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City Hospital, Sydney

Hon. Pres., Miss A. Martin; Pres., Mrs. Hilda Wall; Sec., Miss L. Bagnell; Treas., Miss M. O'Connor, C.H.; *Committee Conveners: Publicity*, Mrs. C. Hillcoat; *Flower*, Miss C. MacNeil; *Rep.* to *The Can. Nurse*, Miss L. Munro.

ONTARIO

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Address all communications to:

THE CANADIAN NURSE
1522 SHERBROOKE STREET, WEST
MONTREAL 25, QUEBEC

L.C.